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The Overrepresentation of Women in ‘Common’ Psychiatric Diagnoses: Do Women’s Magazines Play a Role in Marketing Psychiatric Explanations?

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ABSTRACT

This study is concerned with the over-representation of women in common psychiatric diagnoses and the role played by the mass media in promoting medicalized explanations of distress in women. In order to investigate this, the current study examines the various constructions of distress used in the women's magazine 'Take a Break'. This magazine was chosen because of its popularity and because the readership reflects those women who are demographically most over-represented in common psychiatric diagnoses. In order to investigate the constructions of distress used in the magazine, the study draws on discursive psychology and critical discourse analysis to examine *how* particular constructions of distress are employed and *to what effect*. The key constructions identified in the data were 'distress as a normative response', 'distress as a biomedical condition' and 'distress as a matter of personal responsibility'. The implications of each of these representations of distress are explicitly reflected upon with reference to the literature, and recommendations for clinical practice and further research are made in light of the findings.

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1. INTRODUCTION

In this section I will begin with a brief literature review in order to summarise research findings on gender and psychiatric diagnosis. Firstly, I will present the epidemiological evidence to support the overrepresentation of women in common psychiatric diagnoses. I will then go on to summarise the key explanatory frameworks postulated in the literature to account for these gender differences. I will then critique these accounts using a social constructionist approach, which argues that psychiatric diagnoses are socially constructed and unique to time and culture, rather than being a 'real' physical entity.

I will then go on to argue that the mass media is a powerful tool in promoting particular conceptualisations of distress. To illustrate this argument I will draw on examples in the literature where mass media has been used to promote or market psychiatric explanations of distress to women and I will reflect on the potential implications of this. I will then go on to discuss the relevance of this to Clinical Psychology and will subsequently outline my research aims.

1.1. Gender and Psychiatric Diagnosis

1.1.1. Women and Mental Health: Epidemiological Findings

It is widely reported in the literature that overall rates of 'mental disorder' are identical in men and women (Kessler et al, 1994; Rosenfield & Smith, 2010). Despite similar overall rates, the profiles of psychopathology are reported to differ, with women accounting for more of the 'common mental health problems' such as mood and anxiety 'disorders' whilst men show higher rates of psychotic and substance misuse 'disorders' (Kessler et al, 1994; Rosenfield & Smith, 2010).

Evidence suggests that comorbidity between anxiety and depression is high (Astbury, 2001; Kessler et al, 1994), however, women are more likely than men to receive a diagnosis of either anxiety or depression alone, as well as being more likely than men to receive a comorbid diagnosis (Kessler, 1994; Linzer et al 1996; Simonds & Whiffen, 2003).

Specifically, women's increased rates of depression relative to men have become one of the most consistent findings in psychiatric epidemiology. This was highlighted by Kessler et al (1994) in the US National Comorbidity Survey, but has also been demonstrated by a number of other research studies utilising both clinical and community samples (Linzer et al, 1996; Williams et al, 1995). Further research has also found this phenomenon to exist across a wide range of cultural contexts (Piccinelli & Homen, 1997; Seedat et al, 2009; WHO & ICPE, 2000).

1.1.2. Which Women are Most at Risk?

Due to the particularly large gender differences seen in the diagnosis of depression this area has been extensively researched. Several studies have found that adult women are most over-represented in depression diagnoses with smaller differences in children and older adults (Bebbington, 1998; Kessler et al, 1993; Kessler et al, 1994). The exact age range varies between studies, but there appears to be a general consensus that women are most over-represented between early adolescence and the mid-50s (Bebbington, 1998; Kessler et al, 1993; Kornstein & Wojcik, 2002). In addition, marriage and motherhood further increase a woman's risk of receiving a depression diagnosis (Gove, 1972; Piccinelli & Wilkinson, 2000), with young mothers with small children being at particularly high risk (Bebbington et al., 1981a; 1984; Paykel, 2005).

Whilst much of the literature focuses on depression, evidence suggests that the overrepresentation of women in other psychiatric categories may be mediated by similar risk factors. Simoni-Wastilla (2000) found that women between the ages of 25 and 34 were being prescribed the greatest amount of psychotropic medication. However, they also found a peak of drug prescription for those over the age of 65. In addition they found that precise age differences could be seen depending on which drug was being examined. Whilst middle-aged women were most likely to be prescribed anxiolytic drugs, women below the age of 35 were more likely to be prescribed narcotic-based drugs.

Astbury (2001) also highlighted the added pressures experienced by lone mothers, and reported that even in developed countries lone mothers were most likely to be living in poverty (Belle, 1990) and most likely to suffer from poor physical and mental health outcomes (Belle, 1990; Lipman, Offord & Boyle,

1997). Research also suggests that low socioeconomic status is a risk factor for poor mental health irrespective of parenthood (Hudson, 2005; Kessler et al, 1994).

In line with this evidence, employment appears to be a protective factor against poor mental health. Simoni-Wastila (2000) reported that women in employment were significantly less likely to be prescribed psychotropic drugs. Astbury (2001) reports that rank in the workplace is predictive of depression, with those at the lowest work grades reporting the highest rates of depression. This may well have implications for women, who have consistently lower employment rates than men and who also occupy fewer professional roles and earn consistently less (Office of National Statistics, 2013). This may suggest that women from lower socioeconomic status backgrounds may be at greater risk of receiving a mental health diagnosis.

1.1.3. Explanations for Gender Differences in Common Psychiatric Diagnoses

The gender differences in psychiatric diagnoses are striking and many explanations have been theorised and researched. Given the particular research focus on the over-representation of depression in women, much of the research focuses on this area in particular. Below is a brief summary of the literature which attempts to create a better understanding of these striking epidemiological findings.

1.1.3.1. Biology

Biological differences are often posited as a reason for differential diagnosis rates. The most common biomedical explanation for women's higher rates of anxiety and depression is reproductive hormones. This theory has been justified through the apparent link between anxiety and depression and periods of hormonal flux (Solomon & Herman, 2009). In particular, researchers have noted the association between the onset of depression and/or anxiety and puberty (Angold et al., 1998; Parker & Brotchie, 2004; Peterson et al., 1991), and the lack of gender discrepancy in anxiety and depression post-menopause (Bebbington et al., 1998; Kessler et al., 1993). Some researchers have also argued that the

cross-cultural nature of gender differences in depression is indicative of biological causes (Altemus, 2003).

1.1.3.2. Social Roles

The socialisation of girls and women into particular roles has also been presented as an explanation for higher rates of female depression. As mentioned previously, the largest gender differences seen in depression exist in adulthood (Bebbington, 1998; Kessler et al, 1993; Kessler et al, 1994). Whilst it can be argued that girls (and boys) are socialised into particular roles from very early on, Nolen-Hoeksema and Girgus (1994) suggest that a process of 'gender intensification' occurs at puberty. This involves girls being consigned to limited social roles, which, if rejected, could result in rejection of girls by boys.

Astbury (2001) suggests that the higher levels of depression reported in female adulthood may reflect the triple burden carried by adult women, including the burden of reproductive, productive and caring work. The gendered psychological effects associated with marriage is a well-researched area in relation to this theory, with marriage acting as a risk factor for mental health problems in women and a protective factor for men (Dennerstein et al, 1993). Whilst this finding has been demonstrated to be inconsistent across cultural groups (Russo, 1990), it has been argued that it could indicate that the higher levels of distress found in adult women may be related, at least in part, to the social expectations placed upon them as wives and mothers in particular cultural and socio-political contexts.

As highlighted above, research has also demonstrated that women caring for young children may be at particular risk of depression (Brown & Harris, 1978). Belle Doucet (2003) found that those experiencing poverty were also more susceptible to depression. This echoes a much wider body of research which demonstrates the link between social inequality and poorer physical and mental health (Wilkinson & Pickett, 2010). These two risk factors may well be linked, as even in developed countries lone mothers are the largest group of people living in poverty (Belle, 1990).

Whilst most of the research in this area focuses on depression rather than other common psychiatric diagnoses such as anxiety and somatoform disorders, it is possible that similar mechanisms underlie distress. However, Zalta and Chambless (2012) suggest an additional mechanism that may influence female anxiety. They argue that due to gender socialisation, girls have fewer opportunities to experience mastery in their learning than boys, and that it is this lack of mastery that results in high levels of female anxiety in relation to anxiety in boys.

1.1.3.3. Cognitive Style and Personality Characteristics

It has been suggested by some that the role of adverse life events in causing depression is mediated by individual cognitive styles and vulnerability (Piccinelli & Wilkinson, 2000). Specifically, research suggests that the way in which an individual copes with an initial lowering in mood is key to depression. According to Nolen-Hoeksema et al (1999), men have a tendency to distract themselves from low mood, whereas women are less active in their coping and are more likely to ruminate. It has been suggested that rumination is a less effective coping strategy than taking some form of action, and thus could leave an individual at greater risk of depression (Hänninen & Aro, 1996; Nolen-Hoeksema, Larson, and Grayson, 1999).

Research has also been used to argue that particular personality characteristics associated more strongly with women are helpful in understanding depression rates in women. Goodwin and Gotlib (2004) found that levels of 'neuroticism' were significantly higher among females, and suggested that this characteristic may play a role in mediating depression.

1.1.3.4. Health-Seeking Behaviour

According to the literature, women are more likely than men to report psychological symptoms and to seek help (Leong & Zachar, 1999; Mackenzie, Gekoski & Knox, 2006; Oliver et al, 2005). It has been suggested that women's higher mental and physical morbidity might be related to sensitivity to physical cues or the greater social acceptability for women to seek help (Sen et al, 2002). Interestingly, Kessler et al (1981) found that women were more likely than men to

seek medical help when experiencing similar levels of distress, and that this appeared to be related women's readiness to conceptualise feelings of distress as a recognised emotional problem.

1.1.3.5. Job Inequality and Discrimination

Women in paid work receive significantly lower wages than their male counterparts, and whilst the pay gap varies between countries, women in the UK in 2013 typically earned 19.7% less than their male counterparts per hour (Department for Culture, Media & Sport, 2014). Women are also more likely to occupy lower-status jobs associated with less autonomy (Stansfeld et al, 1998). This is relevant to the distress of women as jobs associated with a lack of control or autonomous decision-making are associated with higher levels of physical and mental illness (DoH, 1998; Stansfeld et al, 1998). In addition women also engage in far greater levels of unpaid domestic and caring work in the home or community which is likely to contribute to distress (Astbury, 2001).

1.1.3.6. Social Rank

In the National US Comorbidity Survey (1994), Kessler et al found that most psychiatric disorders declined with higher socioeconomic status, which is consistent with a body of research into risk factors for psychiatric diagnosis (DoH, 1998; Patel et al, 1999; Saraceno, 1997; WHO, 2001). Whilst the link between socioeconomic status and psychological wellbeing has been well established in the literature, much of this research lacks a gender perspective (Astbury, 2001). However, in the 1998 'Independent inquiry into inequalities in health', the Department of Health highlight some of the inequalities experienced by women, including poorer psychosocial health and higher rates of anxiety and depression. Attention is also drawn to the importance of intersectionality between gender, socioeconomic status, motherhood and ethnicity (DoH, 1998). Whilst much of this research lacks a gendered perspective, it can be deduced that if women are subject to greater levels of social disadvantage (as discussed above), and social disadvantage is associated with poorer psychological outcomes, that women may experience poorer outcomes as a result of this disadvantage. This is

corroborated by the DoH's (1998) finding that women of lower socioeconomic status are at higher risk.

Whilst material indicators of social disadvantage are important to consider, it is also worth noting the significance of conceptual ideas about social rank. Astbury (2001) argues that issues of social rank also operate on a symbolic level, with each person having an awareness of their social position in relation to others. Importantly, the 'symptoms' of depression can be seen to overlap considerably with the qualities experienced in relation to low social rank. For example, experiencing oneself as inferior, behaving in unassertive ways, and experiencing a sense of defeat. Furthermore, from a gendered perspective, these very qualities have significant overlap with societal and cultural expectations of femininity (Astbury, 2001).

1.1.3.7. Gender-Based Violence

The prevalence of violence against girls and women is alarmingly high (WHO, 1998; WHO 2001; WHO, 2002). Girls are far more likely to be victims of childhood sexual abuse than boys (WHO, 2002) and women are far more likely to be victims of intimate partner violence perpetrated by men (Kessler et al, 1995; WHO, 2001). This is of particular relevance to the field of mental and physical health as violence against girls and women has been linked to a vast number of mental health problems (Astbury, 2001; Humphreys, 2007; Ussher, 2010), including depression, anxiety, substance abuse, dissociative disorders and post-traumatic stress disorder (PTSD) (Pico-Alfonso et al, 2006; Roberts et al, 1998) and physical health problems (Humphreys, 2007).

1.2. Critique of the Evidence: A Social Constructionist Approach

Ussher (2010) argues that the various arguments provided above are "at best, partial, and at worst, deeply flawed analyses" (p. 20). Specifically she argues that whilst these explanations vary widely in the way in which depression is understood, they all posit that it is an existing pathology within the woman, whether this results from a biological or social cause (Ussher, 2010). The same argument can be made for the conceptualisation of anxiety or any other psychiatric explanation. It is important to note that the explanations do vary a

great deal with regards to the extent to which they consider social context and gender inequality, but that even very contextualised accounts make little attempt to question the validity of the concept of 'depression' or other psychiatric diagnoses.

These explanations are therefore based on the assumption that a psychiatric disorder is a naturally occurring pathology existing in the diagnosed individual (Pilgrim & Bentall, 1999; Ussher, 2010). This epistemological position is understood as a 'realist' or 'positivist' position, and within a positivist framework, it is assumed that these identified 'disorders' or 'pathologies' can be studied with increasing sophistication aligned with the progress of science, resulting in a more and more accurate description of reality (Burr, 2003; Pilgrim & Bentall, 1999). A range of critics of the realist approach to psychiatric disorder argue that the lack of physical evidence in psychiatry renders psychiatric disorders as problematic at best and completely mythical at worst (Pilgrim & Bentall, 1999; Rapley et al, 2011). Indeed, Rapley, Moncrieff and Dillon (2011) draw attention to that fact that after over 100 years of research into the physical pathology at the root of mental disorder, we are still no closer to identifying or understanding any organic or physical causes of human misery.

An alternative to the positivist approach to psychiatric diagnosis is a social constructionist approach (Burr, 2003). Social constructionism adopts a critical stance towards our 'taken-for-granted' knowledge or understanding about the world, and suggests that the categories by which we understand the world do not necessarily refer to real divisions (Burr, 2003). Within a social constructionist framework, it is suggested that the way we understand the world is particular to a specific time and culture (Burr, 2003). Importantly, therefore, our accepted knowledge about the world does not result from direct and objective observation of reality, but rather results from our observations of the constant daily interactions between people in social life. People within a particular time and culture construct what is experienced as reality between them through social interaction and in particular, language (Burr, 2003).

This approach therefore represents a complete contrast to the positivist approach taken in medicine and psychiatry which proposes that mental disorder is a pre-

existing organic pathology that has been discovered and exists independently of time, place or cultural context. With regards to psychiatric diagnosis, therefore, a social constructionist approach postulates that such disorders are socially constructed phenomena as opposed to 'real' existing organic entities (Ussher, 2010).

1.2.1. The Case for a Social Constructionist Approach

One way in which the case for social constructionism is made is through the examination of historical and cross-cultural accounts of particular concepts. Historical accounts of madness or psychiatric diagnosis illustrate the way in which our understanding has varied according to the political and social context of the time. Similarly, when looking at cross-cultural accounts, it is evident that psychiatric diagnosis is very much a Western concept as opposed to a universal understanding (Summerfield, 2001; Ussher, 2010; White & Marsella, 1982).

1.2.1.1. A Historical Account

Early madhouses were confining those considered deviant in gradually increasing numbers due to reduced tolerance of bizarre or deviant behaviour in the context of industrial and technological changes and an increasingly capitalist society (Scull, 1979). At the time these were not monopolised by any particular professional group but the business was a lucrative one. Several different professional groups were vying for leadership and control in relation to the mad. However, doctors had an advantage when it came to claims of curing insanity due to their professional status and acknowledged power and success in treating ailments (Scull, 1979). During the nineteenth century doctors therefore applied a range of strategies (including lectures, written literature and a push towards placing apothecaries and visiting physicians into current institutions) to secure public acceptance of their view of madness as an illness (Scull, 1979).

During this time positivism and Darwinian ideas about evolution were extremely popular, and psychiatrists needed to establish their place as a 'hard' biomedical science in order to establish public respect for the profession (Porter, 2002). Whilst many contributed to the establishment of psychiatric nosology, it was the work of Kraepelin that established widely accepted notions of psychiatric

categories (Pilgrim & Bentall, 1999; Porter, 2002; Ussher, 2010). Before this time throughout the ages a range of different explanations for distress had been widely accepted, including spirit possession, witchcraft, or physical explanations such as imbalance of chemicals in the body or infections. Importantly, before the end of the eighteenth century, doctors viewed a patient's emotional and spiritual life as directly relevant to their ill health, and the illness was not thought to exist independently of the person (Radley, 1994). It was only in the early twentieth century that depression became a widely used term and became reified as a disorder in the Diagnostic and Statistical Manual for Mental Disorders (Kirk & Kutchings, 1992).

Interestingly, the further construction of asylums and the employment of doctors to treat those considered insane during the nineteenth century led to a rapid increase in the number of certified 'lunatics'. In 1844 there were 12.66 certified cases of mental illness per 10,000 people, and by 1890, this figure was 29.6 per 10,000 (Scull, 1979). Foucault (1965) argues that the language used to construct madness defines madness and the way it is manifested. In other words, in relation to the huge increase in mentally ill, the Foucauldian argument would suggest that once the discourse of madness has entered the minds of the population, it becomes a legitimate way for misery to be communicated, and that this can be manifested both psychologically and physically, leading to a subsequent increase in cases.

Clearly, particular social constructions or accepted knowledge were associated with particular responses. Early assumptions dictated that the mad were 'like wild beasts' that needed 'brutal taming'. This included the use of instruments such as whips and chains (Porter, 2002). Other strategies used included physical restraint, bloodletting and purging and vomiting (Porter, 2002). Later, in the first half of the twentieth century, electro-convulsive shock therapy and insulin-coma therapy were introduced and quickly gained popularity. It has been argued that these approaches were embraced due to their ability to confirm the medical and scientific nature of psychiatry (Moncrieff, 2011). The first half of the twentieth century also saw the introduction of psychopharmacology (Ussher, 2010). However, despite seemingly conflicting epistemological positions, psychiatry in the 1940s-1960s was also heavily influenced by psychoanalysis. This saw

diagnoses of hysteria and nervous conditions being applied primarily to women (Ussher, 2010). Finally in the 1970s the pressure for psychiatry to establish itself as a 'hard' science based on evidence-based principles increased, largely due to the poor diagnostic reliability associated with the DSM-II (Davies, 2013). This led to a rejection of psychoanalytic ideas and the firm establishment of biological explanations for psychological distress (Ussher, 2010).

From a feminist perspective, madness has long been associated with femininity (Meyer, Fallah & Wood 2011), and the early days of psychiatry have been heavily critiqued for widely denigrating female intellect (Porter, 2002). Women were also more likely to be labelled as hysterical or maladjusted and were also more likely to be forced to submit themselves for professional assessment by a psychiatrist or psychologist (Russell, 1995).

Importantly, social constructionism dictates that this passage from one understanding to another does not represent a progression from obscure or ignorant conceptions to a final realisation of the 'truth' about madness (Burr, 2003). Rather, different understandings appear to manifest according to social and political contexts and appear to perform particular social tasks.

1.2.1.2. A Cross-Cultural Account

In the same way that madness or distress have been conceptualised in different ways in Western societies over time, there is also extensive evidence to suggest the way in which emotional states and misery are conceptualised and experienced vary hugely between different societies. Across different languages words can be found for emotional concepts that do not translate directly to other languages, suggesting that emotional experience is socially constructed rather than universal (Burr, 2003).

Similarly, the terms used to describe some kind of mental distress also vary hugely, as do the explanatory frameworks or understandings behind them. As highlighted by Ussher (2010), Marecek (2006) demonstrates this by highlighting some of the ways in which distress is signified in other communities, such as burning sensations on the soles of one's feet in Sri Lanka, and ants crawling inside the head in Nigeria. In Iran a variety of social problems, such as poverty or

family conflicts, are understood to lead to a condition called “heart distress”, which is described as abnormality or disturbance of normal heart function (Good & Good, 1982).

These cross-cultural differences have long presented a problem to Western psychiatry. Historically, patterns of behaviour unique to a particular cultural group were termed ‘culture-bound syndromes’ when they did not fit with Western conceptualisations of psychiatric disorder (Littlewood, 1990). This has since been widely critiqued on the basis that all distress reactions can be seen as culturally determined. For example, overdoses and anorexia nervosa are arguably an artefact of Western culture (Littlewood 1990; Littlewood & Lipsedge, 1987).

Over time there has been an increase in conformity to Western conceptualisations of distress cross-culturally (Littlewood, 1986). Rather than representing scientific progress towards discovering ‘the truth’, this can be seen as a direct result of the increasing dominance of professional western medicine in a context of more general economic and social transformation associated with capitalism (Littlewood, 1990).

Consistent with a social constructionist approach, White and Marsella (1982) argue that in much of the cross-cultural research there has been inadequate attention paid to the power of language used in social contexts and the extent to which illness terms and concepts are embedded in wider cultural systems of knowledge about social behaviour.

1.2.2. Why are Cultural Conceptions of Distress Important?

Cultural concepts are hugely important, as the way in which we understand people and the world will inevitably have a direct impact on the way we act or respond. In order to illustrate this point, Burr (2010) uses an example of ‘drunks’, who, before the Temperance movement, were seen as wholly responsible for their behaviour and were therefore imprisoned as a response. Later understandings of drunkenness moved towards an alcoholic explanation, where the individual is seen as having a sickness or addiction for which they are not entirely responsible. The response therefore changed, with a greater focus on medical or psychological treatment or rehabilitation (Burr, 2010).

Our understood knowledge and social action therefore go hand-in-hand (Burr, 2010), and this is of importance and relevance with regards to psychiatric diagnosis. As described above, historical conceptions of madness have at times legitimised extremely brutal treatment. It is therefore important to consider what actions are currently allowed and legitimised through our current understanding of distress as psychiatric disorder. Moncrieff (2011) suggests that psychotropic medication, rather than targeting specific disease pathways or abnormalities, instead simply creates an alternative experiential state (such as sedation). However, millions of people around the world have been convinced that they are experiencing a brain disorder which can be corrected through the use of psychotropic medication (Moncrieff, 2011). Moncrieff (2011) goes on to argue that this idea is based on marketing tactics of pharmaceutical companies and the need for psychiatry to maintain its professional power. The implications of this are that people are being prescribed drugs that are simply suppressing or disguising their distress (Moncrieff, 2011), thus avoiding the need to examine the root causes (Boyle, 2011).

Whilst psychiatric treatment can therefore be seen to propagate an avoidance of examining the social and political determinants of distress, it is also important to consider the direct impact of medication on individuals. Price, Cole and Goodwin (2009) found that SSRI anti-depressant medication caused a wide variety of unwanted emotional side-effects in users. These included feelings of numbness and a reduction in positive emotions such as happiness, enjoyment, excitement and love; feelings of detachment from loved ones including to partners and children; feelings of indifference about things that used to matter and personality changes. In addition, anti-depressants are well documented to be associated with a whole host of other unwanted side-effects. On the NHS information website (NHS Choices, n.d.) it lists 'common' side-effects associated with SSRIs and these include 'feeling agitated, shaky or anxious, feeling or being sick, indigestion and stomach aches, diarrhoea or constipation, loss of appetite, dizziness, insomnia or feeling very sleepy, headaches' and a variety of sexual problems including low sex drive and difficulty reaching orgasm. Less common side-effects listed include self-harm and suicidality, seizures, fever, irregular heartbeat, unconsciousness or coma. Side-effects of other medications have similarly

unpleasant and worrying side-effect profiles. For example, anti-psychotic drugs are commonly associated with a range of problems including constipation, weight gain, high blood pressure, increased risk of diabetes and reduced life expectancy, to name a few (Bentall, 2010).

Whilst much of this section has focused on psychiatric diagnosis and treatment, it is important to also deconstruct the way in which Clinical Psychology as a discipline constructs distress and what action this allows or inhibits. Whilst as a discipline Clinical Psychology aims to explore sociocultural determinants of distress, it is still arguably complicit with the concept of psychiatric disorder. Boyle (1997) suggests that this collusion occurs in a number of different ways. Firstly, Clinical Psychology can be seen to adopt a theoretically medical framework which substitutes physical pathologies such as bacteria or tumours with unwanted psychological attributes such as 'thinking errors' or 'cognitive biases', or pathological personality characteristics such as 'neuroticism'. Secondly, whilst Clinical Psychology may not explicitly embrace the use of psychiatric diagnoses, it rarely challenges their use, and serves to validate this way of categorising implicitly by organising research using diagnostic groups and referring to diagnosis in psychology textbooks (Boyle, 1997). In addition, psychological services are often created around the diagnostic system and the type of psychiatric diagnosis given can limit the kind of psychological intervention on offer to an individual. Finally, the practice of Clinical Psychology continues to focus primarily on pathological individuals as opposed to pathological social structures which echoes a medical framework (Boyle, 1997).

By colluding with this psychiatric framework, Clinical Psychology perpetuates individualistic and pathologising accounts of distress. Boyle (2011) argues that this rhetoric of objective symptoms and of science serves two key functions. The first, she argues, relates to psychology's insecurity about its academic and social acceptance as a science. In order to establish itself securely within this framework, psychology therefore identifies with and superficially imitates disciplines such as physics, biology and medicine, whose scientific status is perceived as more secure (Boyle, 2011). Secondly, and in relation to the previous point, Boyle (2011) argues that psychology is invested in avoiding accusations of social and political bias, and aims to be seen as seeking the truth as opposed to

being influenced by values. In Boyle's words, psychology is therefore 'much more comfortable talking about brains and minds than about poverty, sexual violence and racial oppression.' Boyle (2011) suggests that this also has the added advantage of avoiding implicating those in power (such as governments, corporations or men) as having a causal role in distress, which might create a retaliation of some kind or threaten their professional position.

Cultural conceptualisations of distress have also been of great relevance to feminist critics, who have long argued that the gender differences in diagnosis serve a function of pathologising women in particular and legitimising the regulation of women's behaviour (Ussher, 1991; Ussher, 2010).

1.2.3. A Feminist Perspective

As highlighted by Ussher (2010), feminist critics have long maintained a critical view of psychiatry and the medicalization of female distress (Marecek, 2006; Stoppard, 2000; Ussher, 1991). It has also been argued that the guise of science and discourse of biology and medicine has been used to mask or ignore the social and political context to distress (Stoppard 2000; Ussher, 1991; 2010).

Unsurprisingly, biological explanations of female depression have received extensive criticism (Ussher, 2010). Critics argue that an unwarranted scrutiny of the relationship between women's reproductive functioning and their mental health has skewed the research agenda (Astbury, 2001), suggesting that research evidence in fact indicates that the effect of biology on a woman's mental health is mediated by, and in many cases disappears entirely, when psychosocial factors are taken into account (Astbury, 2001). For example, Dennerstein, Dudley and Burger (1997) found that emotional wellbeing in middle aged women was positively associated with their general health status, psychosocial and lifestyle variables, and not with their menopausal status or hormone levels. In relation to female depression in adolescents, life events and the interaction between oestrogen and life events have been found to explain four times the variance (17%) in depression compared to oestrogen alone (4%) (Brooks-Gunn & Warren, 1989).

Psychological explanations for depression in women have also been subject to feminist critique. As mentioned previously, some theorists have claimed that it is women's response to stress or adversity which leads to depression. Specifically, women are seen as having a tendency to ruminate as opposed to actively problem-solving (Hänninen & Aro, 1996; Nolen-Hoeksema, Larson & Grayson, 1999). Boyle (1997) argues that such explanations serve to position women as more 'vulnerable' or 'weak' than men. Boyle (1997) suggests that these explanations are more consistent with the dominant scientific and cultural paradigm and are thus more acceptable than exploring or acknowledging political factors and sexual inequality.

Given the problematic nature of psychiatric and psychological explanations for the over-representation of women in common mental health problems, Lafrance and Stoppard (2006) argue that the current dominant psychiatric and psychological discourses of women's depression are individualistic, and based upon an implicit assumption of relative gender equality with the exception of specific biological and cognitive processes. Whilst more contextualised accounts of women's misery or distress are also available in the literature these are often side-lined or excluded from the mainstream. For example, in a review on the over-representation of women in depression, Piccinelli and Wilkinson (2000) simultaneously acknowledge and negate particular social or political factors. In a section on early adverse experiences, it is acknowledged that whilst women are more likely to have experienced certain adverse childhood events such as sexual abuse, they are also 'more sensitive to their depressogenic effects' (Piccinelli & Wilkinson, 2000). This can be seen to maintain an individualistic view of depression and a discourse of female vulnerability.

1.3. Conceptions of Women's Distress: The Role of the Media

We have discussed the socially constructed nature of distress, and the way in which our experiences are shaped and cultivated by the cultural scripts we have available to us. By referring to historical and cultural accounts we have seen that the way distress or madness has been conceptualised varies according to time, place, culture and socio-political context.

There is extensive evidence to suggest that women's distress is being conceptualised as psychiatric in nature both by women themselves and by professionals and wider society. For example, as quoted in the first section of this thesis, Kessler et al (1981) found that women were more likely than men to seek medical help when experiencing similar levels of distress, and that this appeared to be related to women's readiness to conceptualise feelings of distress as a recognised emotional problem. Similarly, when presented with vignettes, women more readily identified the person described as having depression than men did. Interestingly, both men and women were more likely to identify a person as having a mental disorder if they were women compared to if they were male, even if they demonstrated identical 'symptoms' (Swami, 2012). This could arguably suggest that the dominant discourses in society more readily pathologise the emotional experience of women than men.

Ussher (2010) has suggested that the mass media has played an important role in influencing the way we perceive distress. She draws attention to the push for 'mental health literacy', postulating that this has led to governments actively promoting 'depression literacy', and thus widely distributing information about depression as a construct (Gattuso et al; Ussher, 2010). Ussher (2010) goes on to highlight that women's distress has also been consistently constructed as depression in a wide variety of other mass circulation literature (Blum and Stracuzzi, 2004), including women's magazines (Gattuso et al, 2005), health policy (Gattuso et al., 2005), self-help books (Gardner, 2003) and drug company literature (Metzl and Angel, 2004).

1.3.1. How Powerful are Messages in the Media?

The role of the mass media has been researched in relation to a whole host of social problems including the increase in violence and homicide and racial and gender inequality (e.g. Hiebert, 1995; Howitt, 1982). The media has also been of specific interest to psychology in a number of domains, with evidence to suggest that the media is the public's primary source of information about psychological distress (Kalafetalis & Dowden 1997). One particularly well-researched area is that of body image, with a huge evidence base suggesting that unrealistic depictions of beauty in the media play a significant role in body dissatisfaction

and subsequent problems, especially in girls and women (e.g. Cusumano & Thompson, 2000; Grabe, Ward & Hyde, 2008; Hargreaves & Tiggemann, 2003). Another area which has received attention is the role of media in creating or maintaining stigma around psychological distress and psychiatric diagnosis. For example, a study of British television (Rose, 1998) found that the most common themes attached to 'madness' were danger and violence, and that this was the case both for fictional programmes and news stories. In a context where the media is a primary source of information about psychological distress and psychiatric diagnosis, this is likely to have an impact on those experiencing distress (Kalafatelis & Dowden, 1997).

The evidence therefore suggests that there is a link between media depictions, attitudes and behaviours. According to the Foucauldian argument (1965) discussed earlier, this is happening due to the planting of particular ideas about how distress can be expressed in a way understood by and expected by the person's culture. Davies (2013) draws on two particular case examples which support the argument that the media is shaping the way we construct, understand and express misery and distress. The first case he describes involves the death of a 14 year old school girl in Hong Kong who was found at post-mortem to have starved herself to death. At the time this was an extremely rare event in Hong Kong and it received intense media attention, eventually leading to 'anorexia' posited as an explanation. As public knowledge about anorexia nervosa grew, so did reported incidences, with such a sharp incline it was considered a local epidemic (Davies, 2013). In an attempt to make sense of the event, Watters (2010) examined the available evidence. Many argued that Western depictions of beauty or pop culture were to blame, however, Watters (2010) found that what had happened mirrored what also happened in America and Europe once the 'disease' was named. He suggested that once the label and understanding was introduced, it provided an unconscious behaviour through which young women could draw on to communicate their distress (Watters, 2010).

The second case that Davies (2013) draws on is that of deliberate self-harm in Britain in the late 1980s. He reports that during this time increasing numbers of young women were presenting to mental health services with self-inflicted wounds, and the numbers continued to rise dramatically into the 1990s and

2000s. The dramatic trend could not be explained by a general decline in child well-being, which, whilst not ideal, had not decreased during that period (Davies, 2013; Save the Children, 2004). In an examination of references to self-harm in the media between 1966 and 2005, Whitlock et al, (2009) found only 2 films with unambiguous self-harm references prior to 1980, compared with over 50 songs and 20 films between 2000 and 2005. A similar trend was found in printed news articles. Between 1966 and 1990 253 stories were found that referenced deliberate self-harm, compared with 1,750 found between 2000 and 2005. Davies (2013) uses these examples to make a convincing argument about the role of media in influencing the way in which we make sense of and express our distress.

The power of the media is important in the medicalization of women's distress, as evidence suggests that 'normal' female experiences are being increasingly positioned as pathological. In an examination of advertisements for anti-depressant medication between 1985 and 2000, Metzl and Angel (2004) noted a clear shift towards positioning normal reactions to life events experienced by women (marriage, motherhood, menstruation and menopause) as depression, thus warranting medical intervention. In contrast, depression in men was positioned as a biochemical illness, with far less evidence of pathologisation of normal reactions to life events. Munce et al (2004) suggest that the overrepresentation of women in psychiatric advertising has played a role in the over-diagnosis of depression in women. In support of this argument, Malerud and Okkes (1998) found that doctors attribute different meanings to identical symptoms in male and female patients or attribute female illness to psychiatric disorders and prescribe inappropriate psychotropic medication. The insidious nature of medicalization of female distress in the media arguably represents increasing pathologisation of women (Ussher, 2010).

This evidence therefore supports the Foucauldian argument that psychiatric diagnoses and expressions of distress are cultural creations (Foucault, 1965). Importantly, given the inherent link between the way in which we construct reality and the way in which we thus respond, this will likely impact heavily on how women respond to distress. It could be that women are more likely to seek medical help rather than examining the social or political context within which

their distress has arisen. In addition this could also explain to some extent why women are far more likely to be prescribed anti-depressant medication than men (Simon-Wastilla, 2000).

1.4. Summary and Development of Research Questions

1.4.1. Summary

Epidemiological research consistently demonstrates that women are over-represented in all common psychiatric diagnoses. Current mainstream explanations for this include biological and social explanations, but few question the validity of the diagnoses given or explore the socio-political context. Social constructionist approaches argue that psychiatric diagnoses are socially constructed phenomena unique to a particular time and culture rather than existing biological entities. Both historical and current evidence supports the Foucauldian (1965) view that conceptions of madness or distress are created within a culture, and once the public become aware of a particular accepted way of experiencing and expressing distress, the numbers of those experiencing that particular manifestation will increase. Evidence suggests that the media is the primary source of information for the public about madness and distress (Kalafetalis & Dowden 1997), and it plays a vital role in the way people conceptualise and experience distress.

For the purpose of this research, I am therefore interested in how the media constructs women's distress, and how this may contribute to the over-representation of women in common mental health problems. Whereas some previous research has explored the role of mass media in representing distress as psychiatric, most of this has focused primarily on depression, and no research appears to have focused on media specifically aimed at those women most over-represented. For this reason, I want to critically evaluate the discursive strategies used to construct ideas about common forms of distress (commonly labelled as anxiety and depression) in a magazine specifically targeted at those women who are (demographically) most over-represented. That is adult women from lower socio-economic backgrounds, and in particular mothers (Bebbington, 1998; Kessler et al, 1994; Paykel, 2005). Magazines were chosen for two reasons,

firstly, by looking at the readership statistics we are able to ensure that they are targeting the groups of women most over-represented. Secondly, the role of print media in presenting particular conceptualisations of distress appears to be under-researched. One study conducted in Sweden carried out a discourse analysis of personal accounts of depression in newspapers with a gendered focus (Bengs et al, 2008), but these newspapers were not marketed specifically to women and the focus was on personal accounts and depression only. In addition Gattuso et al (2005) examined discourses of depression in two Australian magazines. Whilst this research revealed interesting information about the construction of depression in these sources of media, they were targeted at middle class audiences who are not the most over-represented groups, and the focus was specifically on depression.

1.4.2. Relevance to Clinical Psychology

As highlighted above, particular assumptions and concepts allow particular actions. As argued previously, by implicitly colluding with a biomedical framework and psychiatric diagnosis, Clinical Psychology serves to maintain individualistic and de-contextualised accounts of distress. Smail (2011; Hagan & Smail, 1997a) has consistently argued that a materialist understanding of power is central to understanding psychological distress, and that without addressing real inequalities in power we can do very little to reduce distress (Hagan & Smail, 1997a; Smail, 2011).

These ideas raise a number of concerns and questions related to the practice of Clinical Psychology. For example, by treating distress in an individual, are we inadvertently maintaining social inequalities by placing the problem within the person? Where does our role begin and end in addressing social inequalities or challenging unhelpful constructions of distress? Who are we serving to empower in our work, the profession of Clinical Psychology or the people we are working with?

An alternative to working according to traditional, diagnostically-organised mental health services is Community Psychology. Community Psychology approaches locate distress within multiple contexts, both at the micro-level, such as family and peer group, and at the macro-level, such as socio-political and community

contexts (Orford, 2008). As a result, Community Psychology thus aims to support people to find real ways of overcoming inequalities and becoming empowered (Orford, 2008). This approach therefore has a very different conceptual framework which permits very different responses, which may arguably be of favour to disadvantaged groups.

1.4.3. Research Aims

The aims of the current study are:

- To critically analyse the way mental health and psychological distress are constructed in a widely read magazine targeted at women, with a particular focus on anxiety, depression and somatoform disorders as these are the areas in which the greatest gender divide exists. There will be a specific focus on a magazine targeted at women who are (demographically) most overrepresented in these diagnostic categories.
- To discuss the potential impact this may have on women's understanding of their own mental health and psychological distress.
- To reflect on how this might impact on clinical practice.

2. EPISTEMOLOGY AND METHODOLOGY

I will begin this section by discussing the epistemological stance taken in this research study, and will then go on to discuss the methodology used. I will then explain and justify the data selected for investigation, including the type of data chosen, the sample size and the data collection. Finally I will discuss my data analysis.

2.1. Epistemology

2.1.1. Critique of Realism

As discussed in the previous section of this thesis, the vast majority of research into psychiatric disorders and the gender gap in diagnosis takes a realist epistemological position (Ussher, 2010). Realism assumes that there is a straightforward relationship between the world ('reality'), and our perception and

understanding of it (Burr, 2003; Willig, 2013). The most common position within this framework used in psychological research is 'hypothetico-deductivism' (Willig, 2013). Hypothetico-deductivism originated from Karl Popper, due to his idea that we can never prove with certainty that one thing (A) causes another (B), because no matter how many times we observe it, there is always the possibility that the next time will be an exception to the rule. Popper argued that the only way to have certainty is to falsify a theory rather than verify it. By doing this, he suggested, we can find out what claims are false and thus by a process of elimination we can progress towards 'truth' (Willig, 2013).

This approach has been extensively challenged and critiqued. As discussed in the previous section, realism cannot adequately account for the way in which concepts and understandings vary between time and culture (Burr, 2003; Ussher, 2010). In addition, Willig (2013) outlines a number of other problems associated with using the hypothetico-deductivism method for psychological research. These include the over-reliance on existing theories rather than generating innovative ones, the elitist nature of this approach which alienates people who are not familiar with current theories or practice and the unrealistic nature of hypothetico-deductivism. As highlighted by Willig (2013), Kuhn (1962) argued that in reality, a theory is not necessarily rejected when falsified, and instead researchers often hypothesise that the methodology, design or execution of the research project are to blame for the finding (Willig, 2013).

2.1.2. Social Constructionism

The epistemological position adopted in this study is one of social constructionism. As discussed in the previous section of this thesis, social constructionism, in contrast to realism, denies that our knowledge about the world results from a direct perception of reality (Burr, 2003). Rather, social constructionism argues that human experience is mediated historically, culturally and linguistically (Willig, 2013). We are thus cautioned to be critical towards taken-for-granted knowledge about the world rather than assuming knowledge is universal and objective (Burr, 2003).

2.1.3. Relativism vs Realism

Social constructionism can be seen as an 'umbrella term', under which multiple positions can be held, but all of which share the assumptions outlined above (Burr, 2003). One important distinction between different social constructionist approaches is the position taken on 'reality'. Whilst social constructionist approaches necessarily reject the idea that we can directly observe reality, a continuum exists between a critical realist position and a relativist position (Burr, 2003; Nightingale & Cromby, 1999). Relativism dictates that the only things we have access to are our various representations of the world, and we cannot therefore make any reference to reality or the 'truth'. In other words, there is no understanding available beyond a text (Burr, 2003; Edwards & Potter, 1992). In contrast, critical realist approaches maintain that whilst language (mediated by cultural, historical and political context) constructs the way we understand the world, some concept of reality does exist outside of discourse and texts (Burr, 2003; Nightingale & Cromby, 1999). This approach has been taken by many due to a critique of relativist approaches which can negate the reality of issues such as misery and distress, oppression and social inequality (Burr, 2003; Hepburn, 2003; Ussher, 2010).

For the purposes of this research I will hold a social constructionist critical realist position. Given that I am interested both in the way in which female distress is being constructed and the social and clinical implications of this, it is imperative that the 'real' of female misery and gender inequality is adequately acknowledged. Taking a relative position would imply that all accounts of the world are equally valid, thus making a political stance difficult to justify and uphold (Burr, 2003; Hepburn, 2003).

2.1.4. Macro Social Constructionism vs Micro Social Constructionism

Another distinction made within social constructionist approaches is that of 'macro' social constructionism and 'micro' social constructionism (Burr, 2003). Micro social constructionism suggests that social constructionism takes place within everyday discourse between people in interaction. It is interested in *how* people use language to negotiate an interaction and with what purpose. Within

this framework, multiple versions of the world are potentially available and none is truer than any other (Burr, 2003).

Macro social constructionism acknowledges the constructive power of language but sees this as related to material or social structures, and the impact of power is seen as central to this form of social constructionism (Burr, 2003). Importantly, these two types of approaches are not mutually exclusive (Burr, 2003), and for the purpose of this research study I will endeavour to examine both. The way in which I intend to do this is discussed below.

2.2. Methodology

2.2.1. Discourse Analysis: Discursive Psychology vs Deconstructionism

Discourse analysis refers to the study of language in the construction of social reality (Willig, 2013). However, there are broadly speaking two main versions of discourse analysis, one of which primarily focuses at the level of 'micro' social constructionism (discursive psychology), and the other at the level of 'macro' social constructionism (Foucauldian discourse analysis, deconstructionism and critical discourse analysis) (Burr, 2003; Willig, 2013).

Discursive approaches to discourse analysis were initially introduced to British social psychology by Potter and Wetherell (1987), although the term 'discursive psychology' was later created by Edwards and Potter (1992) (Willig, 2013).

Discursive psychology proposes that language is not a direct representation or direct communication of psychological phenomena such as attitudes or beliefs. Rather, language is used in particular and subtle ways to construct such phenomena and to perform particular actions. In this way language can be used to construct social interaction and our experience of the world (Potter & Wetherall, 1987). Discursive psychologists are therefore interested in *how* people use language in their interactions with each other, and how they use linguistic skills to build specific accounts which can have perform functions with powerful implications (Burr, 2003). For example, Edwards and Potter (1992) examined how factual reports are constructed and how cognitive states are attributed and for what purpose. Discursive psychology can therefore be seen to investigate how participants use language to negotiate interactions and achieve

interpersonal objectives (Willig, 2013). This is relevant to this research as the discursive strategies used in the articles are likely to have a significant impact on the experience of the reader. For example, a 'factual' article written by a professional is likely to have different implications than a 'real life' story written by a reader.

Whilst I am interested in the discursive strategies used in the magazine articles, I am also interested in the way in which discourses adopted are shaped by the wider social, cultural and political context, and, furthermore, what discourses these contexts allow or inhibit. As outlined above, this refers to macro social constructionism. Deconstructionism refers to the analysis of data at the level of macro social constructionism, and draws on the work of Foucault and Derrida (Burr, 2003). Foucault (1965; 1972; 1976; 1979) argued that the culturally sanctioned ideas (or discourses) we hold about people in society (such as the 'mentally ill') are associated with specific implications for how these people may be treated. Deconstructionism therefore involves focusing on 'the historical and cultural specificity of knowledge and the possibilities for social action and power' (Burr, 2003). In this way this approach seeks to critique the discursive worlds that people inhabit and reflect on the way discourse impacts on subjective experience (Willig, 2013).

2.2.2. Critical Discourse Analysis

Critical Discourse Analysis (CDA), like other branches of discourse analysis, refers to a range of approaches that assume language represents social action (Richardson, 2007). Unlike many other forms of discourse analysis (and in particular discursive approaches) CDA takes an explicitly political stance towards data analysis (Benwell & Stokoe, 2006; Wodak & Meyer, 2009). Critical Discourse Analysts argue that if language contributes to the (re)production of social life, then it must also be contributing to and maintaining social inequalities (Richardson, 2007). CDA therefore specifically selects a topic for study which is considered to be a social problem of some kind (Fairclough, 1995).

Another key difference between DP and CDA is that CDA is explicitly interested in both micro and macro levels of social constructionism. CDA therefore attends to the level of textual analysis and discursive strategies used to perform a

particular social function ('micro' social constructionism), as well as considering socio-political functions of discourse and the inherent influence of power structures in the formation of particular conceptualisations ('macro' social constructionism) (Wodak & Meyer, 2009). In this way CDA aims to contribute to 'social wrongs' of the time by analysing sources and causes of social problems or inequalities as well as examples of resistance and possibilities for overcoming (Fairclough, 2001).

Rather than representing a particular methodology, CDA represents 'a critical perspective or stance' within the discipline of discourse studies, potentially drawing on a large number of methods from different disciplines (Fairclough, 2001; van Dijk, 2009). Importantly, whichever methods are selected for analysis they will typically include the following properties: the aim to analyse and contribute to the solution of serious social problems caused or exacerbated by public text and talk, an analysis that allows a critical assessment of abusive discursive practices as well as guidelines for intervention or resistance and finally the analysis should specifically take into account the interest, expertise and resistance of those disempowered by discursive injustice or abuse (van Dijk, 2009).

2.2.3. Discursive Psychology and Critical Discourse Analysis: A Hybrid Approach

As highlighted previously, the aim of this research is to both critically analyse the way in which distress is constructed in the magazine selected for analysis (the 'micro' level of social constructionism), as well as reflecting on and discussing the socio-political functions of the discourse used and the way in which this may position women in ways that disadvantage them (the 'macro' level of social constructionism).

In order to investigate this, I will adopt a 'hybrid' DP and CDA approach as used successfully by Winter (2013). I will use the framework for discourse analysis described by Willig (2013) to identify 'how the text constructs its objects and subjects, how such constructions vary across discursive contexts, and with what consequences they may be deployed' (Willig, 2013). In particular I am interested in identifying the different ways in which psychological distress is constructed within the texts. Such constructions are referred to as 'interpretive repertoires' by

Potter and Wetherell (1987), and different repertoires are deployed in different contexts to perform particular social actions (Willig, 2013).

Alongside this, I have drawn on CDA as a 'critical perspective' (van Dijk, 2009) to allow me to examine the medicalization and pathologisation of female distress as an identified social problem (Ussher, 2010). Subsequently, I have a particular interest in psychiatric and psychological constructions of distress. In addition, as inherent to CDA, this research will aim to contribute to addressing the 'social wrongs' of the medicalization and pathologisation of women's distress by analysing the sources and causes of medicalization, and discussing potential routes of social action and resistance (Fairclough, 2001). The discursive and CDA aspects of my analysis will not be reported in separate sections, and rather the principles of CDA will be drawn on throughout the discursive analysis.

2.3. Description of the Sample

I will be analysing magazine articles about psychological distress and misery from the magazine 'Take a Break'. The magazines will be read for any articles containing references to mental health and the relevant articles selected will be analysed using a hybrid approach borrowing principles from DP and CDA.

2.3.1. Justification for the Sample

As discussed in the previous section of this thesis, the literature suggests that adult women are overrepresented in common psychiatric diagnoses, including depression, anxiety and somatoform disorders (WHO, 2001). In addition, there is some evidence to suggest that married and lone mothers are at additional risk of being given such a diagnosis (Bebbington 1996; 1998; Belle, 1990; Lipman, Offord & Boyle, 1997; Paykel, 1991; Piccinelli & Wilkinson, 2000). Furthermore women from a low socioeconomic status are at higher risk of receiving a diagnosis of depression (Kessler et al, 1994; Stansfield et al, 2003).

Following from this research, I selected a magazine for analysis that explicitly targeted adult women who are in their 'reproductive years' and who are from a lower socioeconomic status. On this basis the magazine 'Take a Break' was identified for analysis. 'Take a Break' was selected using statistics taken from the latest estimates published by the National Readership Survey (2013). The

readership statistics for the top 10 selling women's weekly magazines were examined, and the most popular magazine read primarily by women fitting the above demographics was selected.

According to NRS statistics (National Readership Survey, 2013), 2,030,000 copies of 'Take a Break' were sold between January and December 2013, making it the best-selling women's weekly magazine in the UK. Also, according to these estimates, 68% of the estimated readership of 'Take a Break' magazine are working class and 32% from middle or upper classes. It is estimated that 68% of readers are over 35 and 32% between 15 and 35.

2.4. Data Collection

Weekly copies of the identified magazine, 'Take a Break' were collected over a three month period. The magazines were then carefully read for articles that refer to psychological or psychiatric distress. As a guide, I primarily searched for articles that included explicit references to psychiatric diagnosis, mental health/illness and/or psychological or psychiatric treatment. This was appropriate for guiding the identification of articles as I was specifically interested in the medicalization of distress. However, I did not solely rely on a search for key words, as both implicit and explicit references to distress are important (Willig, 2013). Indeed a text that does not contain a direct reference to acute distress and instead uses a euphemism (such as 'the black dog', used by Winston Churchill as an analogy to 'depression') would tell us a lot about way it is constructed and will be performing a particular social action (Willig, 2013).

To be included in the research, articles were also required to feature distress as a key topic in the article. This was included in the inclusion and exclusion criteria because, on initial reading of the data, some articles were found to reference psychiatric diagnosis or emotional distress briefly, or in relation to an unrelated matter, with no discussion about the possible causes or consequences of distress or about the experience of distress. For example, in a 'real life' style article written by a woman who describes her husband having an affair, she includes the statement 'I was diagnosed with postnatal depression and I turned to Martin for support. He didn't let me down.' This is given in evidence of him being a reliable character prior to the affair. Whilst a psychiatric diagnosis is mentioned briefly,

there is no further mention or discussion about it in the two-page article. This and other similar articles were therefore excluded on the basis that they did not provide adequately rich data for the purpose of this analysis. Finally, articles that focused on the construction of mental health diagnoses or distress in men and children were also excluded, as the research question was specifically interested in the construction of distress in women.

2.4.1. Sample Size

On the basis of the inclusion and exclusion criteria outlined above, 18 relevant articles were found and used in the analysis. Discourse analysts do not typically need to work with a vast amount of data to produce meaningful analyses, and ultimately the amount of data needed is dependent on the research question (Willig, 2013). As discussed, for the purposes of the present study I was interested in the different ways distress was constructed (in other words, the different interpretive repertoires used) through informative articles and personal accounts in the selected magazine articles, and in the implications of these constructions. On this basis, 18 articles was deemed an adequate sample size to provide sufficient opportunity to examine the different interpretive repertoires (Potter & Wetherell, 1987) used to construct distress or common psychiatric disorders. See Table 1 for an overview of the articles selected for analysis, including the genre of the article and a column highlighting which extracts in the analysis came from which article. If an extract was not taken from a particular article, but the article was referred to in the analysis, I have highlighted which section this occurred in.

As highlighted by Jäger and Maier (2009), the number of articles deemed adequate for analysis will be influenced by the frequency of relevant articles and the breadth of ways in which the discursive objects of interest (in this case, distress) are constructed. Therefore, if distress is constructed in a number of different ways and within a range of different contexts, and if different constructions appear quite infrequently, a greater number would be needed to identify the range of interpretive repertoires used (Jäger & Maier, 2009; Willig, 2013). In the case of this research, constructions of distress occurred in the data quite frequently, and an arguably limited number of interpretive repertoires were

evident in the texts, with particular constructions and associated rhetorical devices recurring often.

Article	Genre	Extracts taken from article
'I feel so alone'	Agony aunt	1, 10, 19
'I was abused by my parents'	Agony aunt	9
'Are loan sharks after your kids?'	News feature	2, 7
'She says she slept with my hubby'	Agony aunt	12, 17, 20
'My friend has been cutting herself'	Agony aunt	5, 6
'I struggled to bond'	'Real life' story	(referenced in section 3.1.1.1)
'Supermum vs supershattered'	News feature	4
'Taken from mummy by a rapist'	'Real life' story	3
'I'm too scared to get intimate'	Agony aunt	8
'Mum at breaking point'	'Real life' story	11, 24
'My life has been taken over'	Agony aunt	13, 16, 18
'But she's starving to death!'	'Real life' story	14
'Should I tell my daughters the truth?'	Agony aunt	15, 22, 25
'How to...reduce anxiety'	Self-help	21
'How to cope with Seasonal Affective Disorder'	Self-help	(referenced in section 3.1.3.2)
'Monster in the cupboard'	'Real life' story	23
'My ex has destroyed me'	Agony aunt	
'Abuse has destroyed my life'	Agony aunt	

Table 1.

An important point to note in relation to sample size and data analysis, is that the nature of my research questions means that I aimed to explore 'how' and 'why' particular interpretive repertoires appear in the data, rather than make claims about the representativeness and generalizability of my findings. However, a convincing case has been made for the potential power of the media in shaping

public understandings and conceptions of distress (Davies, 2013; Grabe, Ward & Hyde, 2008; Howitt, 1982; Kalafetalis & Dowden, 1997), and it is important to consider the potential implications of different constructions of distress may have on readers. In addition, as highlighted by McCarthy and Rapley (2001), often a culture can be understood by assuming the culture will show 'order at all points', an observation initially made by Sacks (1992a). The 'order at all points' argument suggests that 'order' (such as particular social practices or 'attitudes') is not only present or observable at an aggregate level, but is also present on a 'case-by-case' basis. In other words, according to Sacks (1992a) we can assume that by examining '*fragments* of a culture, that which operates *across a culture as a whole* will come clearly into view' (McCarthy & Rapley, 2001, p. 162). In accordance with this view, it is therefore possible that examples of the interpretive repertoires identified in this analysis are identifiable in constructions of women's distress in other contexts.

2.4.2. Using Media Text

The use of magazine articles is appropriate in relation to my research question which aims to investigate the 'how' and 'why' of particular conceptualisations of distress in mass media targeted at women. The question of 'why' can be located from a number of different viewpoints, depending on how the media source and audience are conceptualised (Gandy, 2000). For example, if the audience are viewed as the public, and the journalistic articles as viewed as objective reports of the truth, then the purpose can be seen as consciousness raising (Richardson, 2007). Alternatively, if the audience is positioned as a consumer, and the magazine primarily as a business, the purpose will be to sell stories in the most profitable manner possible (Richardson, 2007).

It is also important to consider the media production processes involved in using text taken from magazines. Whilst the magazine under study presents 'real life' stories and 'agony-aunt' style letters written by readers, these articles are in fact written in a very particular and uniform journalistic style. Where the letters included represent 'real' letters written in by readers, they are still likely to have undergone a series of processes including editing and formatting to suit the style of the magazine. The implications of this is that the text under study is not a

naturalistic conversation as would typically be studied using discursive psychology (Willig, 2013).

2.5. Position and Self-Reflexivity

Qualitative research recognises that the researcher will always come with their own values, beliefs and agendas and will thus always shape and influence the research process (Willig, 2013), and it is therefore important that I reflect on my own position in relation to this research. As discussed previously, CDA is an explicitly political approach with a particular social problem under investigation, so an objective position is not sought (Burr, 2003). However, it is still of importance to reflect on my own position and how this influences the current research.

For the purpose of this research I am interested in the use of power, the medicalization of female distress and the subjugation of alternative narratives which highlight social and political context. From my position as a critical researcher, I position the magazine as a business and the audience as consumers (Richardson, 2007). The increase in medicalisation can be persuasively argued to be partially related to psychiatry and consumerism (Davies, 2013; Moncrieff, 2011), and therefore this position has been deemed appropriate for this particular project.

In addition, as is inherent to a CDA approach, I will be considering the power of the magazines and advertisers in creating or manipulating audiences. As discussed by Richardson (2007), media producers may attempt to attract a particular audience in order to attract relevant advertising revenue, and this is often achieved on the basis of attracting people from a particular social class. The magazine I intend to analyse is aimed at an audience from “lower” social classes, and I will therefore remain critical of the possible functions of constructing information in a particular way for this audience.

On a related note, the magazine I will be analysing may contain advice columns. As I am particularly interested in medicalisation, I will be approaching these from a critical perspective, and am interested in whether biomedical explanations are privileged in favour of other narratives, or whether a range of accounts of

explanatory frameworks are presented. I will also be interested in the use of professional titles such as 'doctor' and how discourses of science are used to exert power.

Finally, this research follows from the work of a number of feminist academics, and as a feminist and critical psychologist I have a particular interest in gender inequality and the way in which this is maintained.

2.6. Process

Below I will summarise the process by which I analysed my data according to the principles of Discourse Analysis and CDA.

1. Having chosen my data source, 'Take a Break' magazine, I collected a copy of this magazine weekly over a three month period.
2. The magazines were then carefully read, and each article that met the inclusion and exclusion criteria highlighted above were noted. Before beginning analysis, selected articles were read and re-read to allow me to experience the discursive effects of the text as a reader rather than as a researcher (Willig, 2013).
3. Selected articles were then read and re-read with the intention of *coding* the data in light of the research question. During this process all data that had potential relevance to the research question was identified and highlighted (Willig, 2013).
4. I then began to analyse the data in two phases. The first phase was conducted with the aim to find patterns in the data, both with regards to differences in the content or form of accounts, and the identification of features shared by accounts (Potter & Wetherell, 1987). This led to the identification of different 'interpretive repertoires' used to construct distress (Willig, 2013).

The second (closely related) phase was to examine the function and consequence of different repertoires of distress. This involved forming hypotheses about these functions and effects and searching for the linguistic evidence in terms of rhetorical devices and stylistic and grammatical features (Hepburn, 2003; Edwards & Potter, 1992; Potter & Wetherell, 1987).

During this analysis and discussions I also drew on CDA as a 'critical perspective' (van Dijk, 2009), allowing me to reflect on the social implications of interpretive repertoires, including the way in which particular constructions may serve to disempower women and legitimize power abuses (van Dijk, 2009).

5. The analyses were then reported by presenting the interpretive repertoires identified from the data, with a discussion of how and why these particular interpretive repertoires were constructed. A critical perspective consistent with CDA was drawn on throughout, but issues related to power and social inequality were explicitly reflected on in the discussion section.

2.7. Ethical Considerations

The data used in this study is publicly available information. I am not using any participants, so ethical considerations related to consent, anonymity, confidentiality, deception and right to withdraw will not apply. This research project has been registered with and ethically approved by The University of East London.

3. ANALYSIS

3.1. The Data Sample

As highlighted in the methodology section, 18 articles were selected for analysis on the basis of meeting the inclusion and exclusion criteria. These articles consisted of five 'real-life stories', two 'self-help' articles, two 'news report' articles, and nine 'agony-aunt' style articles. The articles were analysed using the steps outlined in the methodology section. Three overarching interpretive repertoires were identified. These were: 'Distress as a Normative Reaction', 'Distress as a Biomedical Condition' and 'Distress as a Matter of Personal Responsibility'. Each repertoire consisted of a set of particular assumptions and employed a range of rhetorical devices to position the construction as valid and convincing. The analysis will be presented in the format of the following subsections:

Distress as a normative reaction

- Psycho-social 'cause' of distress

- Corroboration and consensus: a universal response
 - o Corroboration from an expert: reporter of truth
 - o Corroboration of personal stories: it happened to me too
- Hardship, trauma and the need for support

Distress as a biomedical condition

- Biomedical discourse: reification of diagnosis
- Mentally ill: irrational and out of control
- Acceptance and the need for medical management

Distress as a matter of personal responsibility

- Personal responsibility to control distress
- Responsibility to keep quiet: secrecy, shame and protecting others

It has been recommended by some that when reporting discourse analytic research, it can be preferable to merge analysis and discussion sections (Willig, 2013). This is because a meaningful analysis of this kind can only really take place within the context of a discussion about the insights generated by the analysis (Willig, 2013). For this purpose, initial discussions will be included throughout this analysis section. Whilst CDA will be drawn on throughout the analysis, I will use the discussion section of this thesis to explicitly reflect on the way in which language contributes to social inequalities experienced by women in a mental health context.

3.1.1. Distress as a 'Normative' Reaction to Context

This interpretive repertoire is used in ten of the articles. This repertoire refers to the construction of distress as a 'normal' and 'understandable' reaction to situations that are highly stressful or traumatic. This construction occurs within two key contexts, the context of motherhood and the burden associated with a caring role, and in the context of victimisation in a variety of contexts including childhood abuse, sexual abuse and bullying. The articles within this repertoire all follow a similar structure, in that they include a cited 'cause' of distress, corroboration from others that the distress is a 'normal' and common response, and recommendation for intervention, generally positioned within a framework of support but advocating for help from a 'professional'. A number of discursive

strategies are used to construct this repertoire, and I will discuss these using example extracts from the data below.

3.1.1.1. Psycho-Social 'Cause' of Distress

As highlighted above, articles that construct distress as a normative reaction either explicitly or implicitly posit a psycho-social 'cause' of the individual's distress. By far the majority of articles within this repertoire cited victimisation or stress associated with motherhood as the 'cause', with ten articles referencing victimisation and five referencing the burden of care. Below is an example of an explicitly identified 'cause' of distress:

Extract: 1

5 I'm a disabled single mum with two sons. A year ago I lost my
6 dad to cancer and six months later my mum had a massive
7 stroke.
8 This has left me severely depressed.

In this extract the author has explicitly named a number of psycho-social 'causes' for her depression, and the causal link has been expressed with certainty using the statement 'This has left me severely depressed'. 'Causes' include her mother's illness and the loss of her father, and the inclusion and positioning of the statement 'I'm a disabled single mum with two sons', invites the reader to construct this as also being of relevance to the author's experience of depression. This concept is supported by evidence in the literature, which suggests that lone mothers are more likely to suffer from poor physical and mental health outcomes than mothers in relationships (Belle, 1990; Lipman, Offord & Boyle, 1997). In addition, assumptions about lone mothers, disadvantage and poverty are also represented more widely in political and professional discourses in society (Fineman, 1991). The construction of the extract and the availability of these discourses arguably invite the reader to construct the author's distress as 'understandable'.

Such references to the 'strain' of caring and of motherhood are not unique to this article, with the article 'Mum at breaking point' citing caring for a disabled child as the cause of 'severe clinical depression', and the article 'my friend has been cutting herself' referencing lone motherhood as a key source of distress. In addition, two articles focus on the strains of being a new mother, citing this as relevant to 'maternal suicide' and 'post-natal depression' ('Supermum vs Supershattered' and 'I struggled to bond').

Bereavement and loss, also referenced in the extract, also arguably represent 'understandable' sources of distress. Whilst there is a preoccupation in modern UK society to study and conceptualise 'healthy' and 'pathological' responses to bereavement, there is also a widely held view that loss of a loved one is associated with emotional pain and grief (Valentine, 2008).

Another example of an identified psycho-social cause is that posited in the article 'Are loan sharks targeting your kids?' In this article distress is suggested to be an understandable result of victimisation by loan sharks:

Extract: 2

94 Tony Quigley says: "I know of a case where the loan shark sat
95 outside the person's property for hours."
96 "It's like water torture and sometimes it boils over to the point where
97 victims feel so depressed they feel they don't have the ability to
98 continue living any longer."
99 In fact, Tony believes that his team have prevented around 25
100 suicides.

In this extract, harassment and victimisation by loan sharks is described using 'water torture' as a *metaphor*. Wood and Kroger (2000) argue that metaphor can be used discursively to perform a range of functions, including 'hedging' or weakening claims or justifying an argument. In this example, the metaphor appears to be employed as a rhetorical device to communicate the extreme nature of harassment. In turn, this constructs subsequent distress as normal and

expected given the extremity of the context. The construction of the extreme nature of distress in this way may also serve to justify the later claim that 'his team have prevented around 25 suicides', which would arguably be difficult to evidence and open to challenge.

Another example in which victimisation is constructed as the 'cause' of distress is included below. This extract is taken from the article 'Taken from Mummy by a rapist'.

Extract: 3

106 I had to watch as Mum did everything for my little boy and I ached
107 inside. Billy was the only person I really loved and it felt as though
108 she had stolen him from me.
109 Soon after, John raped me again and I fell into a black hole of
110 depression.

This article is written by an author as a 'real life story'. In it, the author describes becoming pregnant as a teenager after being raped by her stepfather, but feeling unable to tell her mother. The baby is then brought up by the author's parents. In this particular extract, attribution for the author's 'depression' is implicitly made to two key 'causes': loss of the mother role and sexual abuse. Once again, these represent 'understandable' causes of depression or distress, consistent with dominant discourses in UK society.

Firstly, the dominant discourse in UK society about motherhood is sentimentalised, with mothers constructed as being self-sacrificing, consumed with love and ever available for and dedicated to her child (Bassin, Honey & Kaplan, 1994; Hays, 1996). Within this conceptual framework, it is therefore 'understandable' that the loss of the author's child would lead to significant distress. A number of rhetorical devices are used to construct the extent of the distress in relation to separation from the infant. Firstly, an *attribution of blame and responsibility* is inherent in the description 'I had to watch as Mum did everything'. The use of the phrase 'had to' positions the author's lack of maternal

role as both against her wishes and out of her control, *externalizing* responsibility from the author and instead attributing blame to her mother and stepfather. Edwards and Potter (1992) suggest that 'actions in descriptions' are a common feature of discourse, frequently used to attribute blame or responsibility.

In this extract, the use of an *emotional metaphor* is also deployed, in the description 'I ached inside'. Edwards (1999) suggests that emotion metaphors are conceptual resources used to perform particular rhetorical functions. In this particular example, the author is equating her emotional experience with physical pain, perhaps in order to emphasise the 'realness' or 'tangibility' of the experience, or to emphasise the extremity of distress.

Another rhetorical device in use in lines 106-107 is the use of *extreme case formulation*. Pomerantz (1986) identified extreme case formulations, identifying them as using extreme terms such as 'always', 'never' or 'brand new'. Extreme case formulations can perform a number of functions, including defending against accusations or justifications, to construct something as objective or 'fact', or to propose that a particular behaviour is 'right' or 'wrong' in accordance with the frequency in which it occurs (Pomerantz, 1986). In this extract the use of 'everything' is used to construct the powerlessness of the author. The term 'only' in line 107 is also used to highlight the value and priority of the baby and subsequently construct the level of distress as severe.

In addition to the loss of her child, the author also constructs rape as a 'cause' of depression. Whilst a causal link is not made explicit, the inclusion of the statement 'John raped me again', and the positioning of it as preceding 'and I fell into a black hole of depression' invites the reader to construct this as relevant to the subsequent distress. As documented in the introductory section of this thesis, this is consistent with empirical findings that rape and sexual violence are linked with a wide variety of psychiatric diagnoses (including depression, anxiety, substance abuse, dissociative disorders and post-traumatic stress disorder (PTSD) (Pico-Alfonso et al, 2006; Roberts et al, 1998). Arguably, this also reflects Anglo-American institutional discourses on rape, which position those who have experienced rape as 'victims' who are 'traumatised' (Hengehold, 2000). The

author is therefore drawing on a commonly accepted 'cause' of female distress. Whilst the link between sexual violence and distress is implicitly understandable and arguably symptomatic of sex inequality, some critics have argued that the pervasiveness of 'victim' discourses in society serve to position women as passive and weak (Kitzinger & Thomas 1995).

3.1.1.2. *Corroboration and Consensus: A Universal Response*

Another way in which distress is constructed as 'normal' within this interpretive repertoire is through constructing distress as universal or corroborated by others. According to Edwards and Potter (1992), *corroboration* and *consensus* are rhetorical devices used to strengthen a particular argument or make a construction more convincing, based on the logic that a greater number of people are less likely to be wrong. In the identified articles, corroboration and consensus were used within two different contexts, one being corroboration by an 'expert', and the other being corroboration by somebody with personal, lived experience. These will both be discussed using examples below.

3.1.1.2.1. *Corroboration from an Expert: Reporter of Truth*

The excerpt in the previous section, taken from 'Are loan sharks targeting your kids?' (Extract 2) demonstrates the use of corroboration by an expert to strengthen the argument that distress is a normal response to victimisation by loan sharks. The quote provided in lines 94-98 is reported to be by 'Tony Quigley, head of the Illegal Money Lending Team in England' (line 38). The use of this quote is therefore an example of *category entitlement*, where the point made is constructed as coming from an 'expert' and thus a credible source (Potter, 1996). In lines 99-100, a claim is made that the team have 'prevented around 25 suicides'. This use of a concrete figure is a rhetorical device which situates the claim within a discourse of 'fact provision'.

Another example is that used in the article 'Supermum vs Supershattered':

Extract: 4

27 Caroline Flint, midwife and author of *Do Birth – A Gentle Guide to*
28 *Labour and Childbirth* says that not only are we not caring for new
29 mums enough, we are failing them.
30 She says: ‘The biggest cause of maternal death in the UK is suicide
31 – and that says to me we are really not treating women correctly
32 after they’ve given birth.

This is another example of corroboration (Edwards & Potter, 1992) given added weight through the ‘expert’ position of the individual corroborating the claims made in the article. In this article an argument is made that ‘instead of having time to recover, [new mums] are thrown into a world where they feel pressured to do housework, juggle the care of their baby with that of other kids, do the shopping and host guests.’ The argument that this commonly results in distress is therefore strengthened by the use of category entitlement (Potter, 1996), allowing this message to be delivered from a source deemed credible to the reader on the basis of their profession as a midwife and arguably also their status as a published author. The quotation of a statistic also serves to demonstrate *consensus*, as the problem is experienced by many others (Edwards & Potter, 1992). In addition, the use of statistics is also an example of *empiricist warranting*. Empiricist warranting is described by Edwards and Potter (1992) as the presentation of information as if it is a straight-forward presentation of facts in the absence of any interpretive work by the reporter.

3.1.1.2.2. *Corroboration of Personal Stories: It happened to me too*

Another way in which corroboration (Edwards & Potter, 1992) is routinely used within the interpretive repertoire of distress as a normative response, is through the reporting of ‘personal stories’. For example, in the article ‘My friend has been cutting herself’, an ‘agony-aunt’ style is used in which an author writes in with a problem, and the article is responded to by somebody with personal experience and understanding of the problem. This is a regular feature of the magazine. In this particular article, the original author reports:

Extract: 5

5 My best friend has a stressful life – her ex-partner was abusive and
6 she's now a single mum with two young children.
7 She struggles and has been self-harming for many years.

To which the respondent replies:

Extract: 6

12 TaB Buddy Dee, 32: 'I began self-harming in my late teens. There
13 was a lot going on in my life and I was full of emotions I couldn't
14 express.
15 Cutting myself allowed me to let go of the anger, frustration and
16 fear.

The respondent's identification with the reported problem of self-harm as attributable to psycho-social circumstances serves to *corroborate* the original hypothesis. In addition, because the author is reportedly speaking from the position of their own experience, this arguably qualifies the statement in a similar way to category entitlement by 'experts' (Gee, 2011).

This is a common feature in all six of the 'agony-aunt' style articles within this interpretive repertoire. This form of 'corroboration' (Edwards & Potter, 1992) is also used in addition to category entitlement in the articles referenced above. In the article 'Are loan sharks targeting your kids?' the article describes the victimisation of a woman:

Extract: 7

134 Too frightened to call the police, Jayne continued to pay all she
135 could.
136 She says: "I felt like I had nowhere to turn."

137 Finally, she fell into such a deep depression that she had to be
138 admitted to hospital.

The use of corroboration by both an expert and an individual who has personal experience arguably constructs the argument as particularly powerful. Also of interest in this excerpt is the way in which Jayne's distress is constructed. Jayne is described as having 'fell into' a depression, and she subsequently 'had to be admitted to hospital'. This constructs Jayne as passive to her experience of distress and the subsequent treatment she received. Again this could be seen as another rhetorical device to construct the 'normality' of depression, as it could arguably indicate that anyone could be powerless to depression given the extreme stress of the situation.

3.1.1.3. Hardship, Trauma and the Need for Support

Another key feature of the interpretive repertoire of 'distress as a normative reaction' is the way in which responses to distress are constructed. Throughout these articles women are positioned as needing 'support' or 'treatment', including social support, counselling or talking therapy and medical support. Below is an excerpt from the article 'I'm too scared to get intimate':

Extract: 8

20 'We took things at my pace and I had more counselling. This might
21 help you too, as the trance-like feeling you describe – known as
22 dissociation – is a symptom of post-traumatic stress.

In this excerpt a woman is responding to an 'agony-aunt' style letter from another woman who is experiencing distress in relation to sex with her partner which she attributes to a historical experience of sexual assault. The respondent is sharing a similar experience, and making recommendations based on her own experience of 'recovery'. In particular, the respondent is advising the original author to seek 'counselling'.

A number of rhetorical devices are used to construct this as a convincing argument. Firstly, as mentioned in the previous section, by constructing the argument as speaking from one's own experience, it is arguably made more persuasive (Gee, 2011). In addition, the author draws on *biomedical discourse* by constructing the experience described by the original author within a psychiatric framework. This is achieved both by the use of a diagnostic label: 'post-traumatic stress', and through the use of the term 'symptom', conjuring associations of medical illness. This biomedical terminology is also an example of *empiricist warranting* (Edwards & Potter, 1992; Potter, 1996), as scientific discourse is drawn on to make the recommendations appear reliable and factual. The inclusion of the phrase 'known as dissociation', is an example of *consensus* used to construct the 'symptom' of dissociation as a universally accepted truth rather than an argument made solely by the author of the text (Edwards & Potter, 1992).

In critique of the construct used in this article, it has been argued by many that the use of the term 'trauma' and a biomedical framework serves to individualise distress, removing the focus from perpetrators and abusers and placing it instead onto victims (Johnstone, 2011). This is echoed in the suggestion that the author in this article seek 'counselling'. In this way, she is seen as the key focus of intervention, with no discussion about seeking social justice or addressing the social inequalities that permit abuses to take place (Johnstone, 2011).

The following extract is from a letter in an 'agony-aunt' style article called 'I was abused by my parents'. It is written in response to an author who wrote in describing the emotional impact of childhood abuse.

Extract: 9

26	I strongly advise you to seek professional help. If you try to keep the
27	past inside you, it will come out in other ways, such as physical
28	illness or depression.

In this extract the respondent advocates that the original author seeks 'professional help'. This is constructed as important and urgent through the use of

the term 'strongly', and this is further legitimized by the author's position as someone who has personal experience of abuse and who sought support from a 'therapist'. The original author is then warned that if they do not seek help they may experience 'physical illness or depression'. This constructs professional help as necessary, and subsequent suffering as inevitable if help is not sought. Furthermore, depression and physical illness are also constructed here as legitimate expressions of distress, contributing to the idea that depression represents an 'understandable' form of distress, but still one which requires 'professional' management.

In the article 'I feel so alone', a variety of recommendations are made to the original author by the respondent:

Extract: 10

16 'Start by going to see your GP. Explain your situation and ask for
17 counselling to help with the grief you're feeling over your dad's
18 death and your mum's illness.
19 'Your doctor may suggest medication or even acupuncture which
20 I have found relaxing and helpful.
21 'Ask about the Complex Needs Team in your area – you can
22 refer yourself or be referred via your doctor. They will give you
23 strategies to deal with the issues you find most challenging.
24 'Next, deal with the practicalities of your daily life. If you need
25 some time out, see a social worker and ask for respite to help
26 with your kids. The charities Mind (mind.org.uk) or Home-Start
27 (home-start.org.uk) can offer support.

In this extract the respondent makes a number of recommendations, including sourcing support from the 'GP', the 'Complex Needs Team' a 'social worker' and charitable organisations. Importantly, these recommendations include biological, psychological and social interventions. Whilst a number of suggestions are made, the primary recommendation is to visit the GP and ask for counselling. This is clearly prioritised by the instruction 'Start by', marking out this action as the first

action to be taken. It could be argued that, in a similar fashion to the previous extract, by constructing medical and psychological intervention as the most urgent or important intervention, distress is being 'individualised' (Johnstone, 2011), with interventions related to the social context presented as secondary or 'adjunct'.

Whilst prioritising the medical and psychological interventions can be seen to individualise distress, the presence of other psycho-social interventions does indicate, at least to some extent, that the social context is also of importance. Another example of this is present in the article 'Mum at breaking point':

Extract: 11

75 I was prescribed anti-depressants that lifted my mood, but they
76 couldn't help me with the day-to-day struggle.

In this extract the author highlights the fact that medication cannot help 'with the day-to-day struggle'. This appears to challenge the dominant discourses in the majority of texts which reference psychiatric management positively (see 'biomedical' repertoire below), and acknowledge the 'real' of distress related to the caring role.

3.1.1.4. Distress as a 'Normative' Reaction to Context: Initial Summary and Reflections

In the interpretive repertoire 'distress as a normative reaction', a narrow range of distressing life experiences are either explicitly or implicitly highlighted as causing subsequent distress. The particular experiences highlighted were consistent with the evidence base and dominant discourses in society about women and trauma, given attention has been paid to the burden on managing multiple social roles and women are overwhelming more likely than men to be victims of interpersonal and sexual violence (Astbury, 2001).

Interestingly, although distress was conceptualised as ‘normal’ and ‘understandable’, in many cases it was simultaneously constructed within a psychiatric framework, with women being consistently encouraged to seek help from a ‘professional’. This arguably individualised and medicalized women’s distress by placing the problem and site of intervention within them, rendering them passive in the process. The implications of this will be considered further in the discussion section.

3.1.2. Distress as a Biomedical Condition

In the extracts above, there are already examples of the construction of distress in psychiatric terms. However, there appeared to be a distinct ‘biomedical’ interpretive repertoire in the data, in which distress was constructed within a strictly medicalized and traditionally psychiatric framework. A number of discursive strategies were used to construct distress in this way, including the use of biomedical terminology such as ‘symptoms’, formal ‘diagnoses’ and ‘medication’, and the reification of diagnoses. Unlike the previous section, within this interpretive repertoire there was little or no discussion of interpersonal factors or social context as having any relevance to the distress. Another characteristic of this interpretive repertoire was that actors experiencing a ‘biomedical condition’ were positioned as irrational, out of control and at times a danger to themselves or others. These constructions will be discussed below using example extracts from the data.

3.1.2.1. *Biomedical Discourse: Reification of Diagnosis*

The excerpt below is taken from the article ‘She says she slept with my hubby’. In this ‘agony-aunt’ style article, an author writes that her best friend recently ‘slept with’ the author’s husband. A respondent replies with the following:

Extract: 12

- 13 TaB Buddy Natalie: ‘As a bipolar sufferer and betrayed wife myself,
14 I hope I can be of some help to you. Bipolar disorder causes

15 massive mood swings – in my “up” moments, I feel as if I could
16 conquer the world, but when I’m “down”, life looks utterly bleak.

Here the diagnostic label ‘bipolar disorder’ is *reified*. Reification is a rhetorical device used to construct an abstract concept as a material thing (Potter, 1996). In this instance, reification allows the author to make the statement ‘Bipolar disorder causes...’ without question about the validity of the concept. In addition, this claim is made with total certainty as opposed to a more tentative claim such as ‘bipolar disorder can cause...’ This can be seen to contribute to the reification of the concept, constructing the claim as fact. The description of the effects of bipolar disorder – ‘massive mood swings’ – also reflects a framework of ‘symptomology’, consistent with psychiatric discourse. The implicit claims made about the validity of bipolar disorder are then *corroborated* (Edwards & Potter, 1992) by the author’s own reported experience of ‘mood swings’, validating the construction of bipolar disorder as ‘real’.

A second example of the use of a biomedical framework is included below, taken from the article ‘My life has been taken over’.

Extract: 13

5 Ever since I was a little girl I’ve had funny habits and behaviours,
6 and last year I was finally diagnosed with obsessive compulsive
7 disorder (OCD).
8 I’m glad I have a diagnosis but I’m still struggling to manage my
9 condition

In this excerpt the author informs the reader that since she was young she has had ‘funny habits and behaviours’, and that last year she was ‘finally diagnosed with obsessive compulsive disorder’. The inclusion of information about ‘funny habits’, and the use of the word ‘finally’ implies that the author had been experiencing OCD for most of her life despite being undiagnosed. As in the previous example, this serves to *reify* (Potter, 1996) OCD as a real ‘thing’ that ‘exists’. In addition, the life-long aspect of OCD described in this excerpt arguably

fits within a biomedical framework in which OCD could be seen to relate to genetics or brain biochemistry, as no clear social or contextual factors are discussed in the aetiology of the problem.

In lines 8-9 the author goes on to write that they are 'glad' to have a diagnosis but struggle to 'manage' their 'condition'. This clearly reflects language used to construct physical illness, where receiving a diagnosis is considered useful because it provides a framework for understanding the experience and it helps 'professionals' to direct 'treatment' (Walker, 2006). The use of the word 'condition' also reflects the language used to construct physical illness. Walker (2006) argues that the use of this construction likens psychiatric diagnosis to that of a condition such as diabetes, which requires management for the rest of the individual's life by the use of medication or other professional intervention. Walker (2006) goes on to argue that this framework thus legitimizes professional intervention by constructing a psychiatric condition as something the person "has". In other words, it reifies (Potter, 1996) the label.

The following extract is taken from the 'real life story' style article 'But she's starving to death!' In this article a woman writes a story about her daughter being diagnosed with anorexia.

Extract: 14

53	Picking at her rice. Doing dance classes. Calorie counting. Hiding
54	food.
55	Suddenly the penny dropped and I was filled with a sense of dread.
56	As a child I'd suffered from anorexia. I'd done all the things that
57	Jade was now doing and I realised she was suffering from the same
58	illness

In this extract several rhetorical devices are used to construct anorexia as biomedical and reify the diagnostic label. Firstly, the extract draws on a *script formulation* (Edwards, 1994), in which the listed behaviours in lines 53-54 are constructed as directly attributable to 'anorexia'. The diagnosis itself is also *reified*

(Potter, 1996) in a number of ways. Firstly, the use of the phrase ‘the penny dropped’, and the verb ‘realised’ construct ‘anorexia’ as pre-existing and real, and waiting to be ‘discovered’. The use of psychiatric and biomedical language (‘anorexia’ and ‘illness’) also serve to reify the diagnosis. The ‘danger’ of the diagnosis is also indicated through the author’s description of her emotional state using the emotional metaphor: ‘I was filled with a sense of dread’. As discussed by Edwards (1999), emotion discourse can be drawn on to perform a number of rhetorical functions, and in this case the emotion metaphor appears to be used to construct the ‘seriousness’ of the ‘condition’.

3.1.2.2. *Mentally Ill: Irrational and Out of Control*

As mentioned previously, there is a clear tendency within the biomedical interpretive repertoire to construct those experiencing psychiatric distress as behaving irrationally. One example of this is the excerpt below, taken from the article ‘Should I tell my daughters the truth?’

Extract: 15

5 My mum suffered from depression and one of my earliest memories
6 is seeing her sitting at the kitchen table, scratching her face and
7 saying she wanted to die.
8 It turned out that my grandma had also suffered mental health
9 problems and I grew up convinced that it would be my fate too.
10 Sure enough it was, although I’ve always been able to control my
11 depression and managed to hide it from my two daughters. They’re
12 now in their teens and I wonder if I should be honest with them.

This letter opens with a description of the author’s mother in lines 5-7. In this description a *dispositional formulation* is used. Dispositional formulations are a type of *script formulation*, in which actions are constructed as being attributable to the disposition of an individual, including their moral, personal and pathological traits (Edwards, 1994). In this case, the author describes a distressing scene of her mother harming herself and speaking about wanting to die, and this is directly

attributed to her 'depression'. The scene described is also made distressing by being constructed as one of the author's 'earliest memories'. Dominant discourses about children in the UK are of 'innocence', 'vulnerability' and these discourses come with moral implications about social responsibilities and the child's 'need for protection' (Meyer, 2007). Within this context, the description of a distressing scene as an early memory can be seen to construct the behaviour as contravening an accepted moral norm (particularly for mothers) of protecting children. This serves to reinforce the notion that due to the pathological nature of her 'depression' she is behaving irrationally.

Another example of 'irrationality' as a construct is demonstrated by the excerpt below, taken from the article 'My life has been taken over'.

Extract: 16

8 I'm glad I have a diagnosis but I'm still struggling to manage my
9 condition – I scrub the floors and surfaces of my house constantly
10 and never invite anyone round in case they bring dirt or germs
11 inside. I've lost all my friends and I'm so lonely.

In this extract the author describes behaving in a way that is making her unhappy, but constructs this behaviour as out of her control due to her 'condition' (OCD). One way that this is constructed as out of control is the use of the term 'struggling', which suggests difficulty and resistance despite the author's best efforts. The author also draws on *extreme case formulations* (Pomerantz, 1986) through the use of the terms 'constantly', 'never' and 'all'. The extreme nature of this construction emphasises to the reader both the irrationality and uncontrollability of the behaviours and the severity of the 'condition'.

A further example of the construction of psychiatric distress as irrational is shown below. This is taken from the article, 'She says she slept with my hubby'.

Extract: 17

17 'Because of my illness I've acted out of character and done things I
18 regretted – including having an affair. Once it was over, I fell into a
19 deep depression.

In this extract the author directly attributes 'out of character' behaviour to her 'illness' (bipolar disorder). This could arguably serve a number of functions. Firstly, it appears to *mitigate* the author from blame for the affair, as the behaviour is attributed to the 'illness' and therefore positioned outside of her control. This is reinforced by the statement 'Once it was over, I fell into a deep depression'. 'I fell' positions the author as passive to the experience. In addition, Edwards (1997) argues that emotion words are routinely used to perform a range of functions, including attribution of blame or mitigation. By informing the reader that she 'fell into a deep depression', the author may be communicating a moral judgement on the affair, feeling guilt and shame, but powerlessness against it in the context of the lack of control associated with bipolar disorder. Whilst the externalisation of the behaviour in the above excerpt serves to mitigate blame, it arguably also positions the actions of those with a diagnosis of bipolar disorder as 'irrational' and 'out-of-control'.

3.1.2.3. *Acceptance and the Need for Professional Management*

The final sub-section under the *biomedical repertoire* is 'acceptance and the need for medical management'. Ten of the articles analysed explicitly referenced the need for medical intervention. Below is an excerpt taken from a letter written in response to the letter quoted in extract 16, and it provides information about the author's own experience of 'OCD' and how she 'manages' the 'condition'.

Extract: 18

16 'All I wanted was to lead a happy "normal" life, but I believed it
17 would never be possible. In my darkest times, I even considered
18 ending it all.

19 ‘However, with the right help and treatment, I’ve learnt how to
20 control my compulsions, and I’m beginning to lead the kind of life I
21 always dreamt of.
22 ‘It won’t be long before you too get to this point. The hardest part is
23 admitting your problems and facing them. You’ve done this. Now go
24 and see your GP.

In lines 16-21 the author has used the rhetorical device of *contrast* (Boyett, 2008). By constructing her life prior to receiving ‘the right help and treatment’ as extremely distressing and almost intolerable, and life after as ‘beginning to lead the life I always dreamt of’, the author is able to demonstrate the significance and power of the treatment she received. This demonstration of the favourability of treatment serves to legitimise the author’s later instruction ‘Now go and see the GP’. In addition, as mentioned in reference to several of the previous extracts, this command is further legitimised by the fact that the author is speaking from the position of her own experience. This acts as a corroboration and constructs her a more credible (Edwards & Potter, 1992; Gee, 2011).

Also inherent in this excerpt is the *reification* of OCD (Potter, 1996). This is achieved through the use of ‘right’ when describing treatment in line 19, as this implies that there is a ‘right’ and ‘wrong’ way to respond to the to OCD, suggesting it as an observable, measurable and treatable ‘thing’. Similarly, in lines 22-23, the author states ‘The hardest part is admitting your problems and facing them.’ Again this positions the ‘problems’ (OCD) as ‘real’ and in need of ‘acceptance’.

A very similar example is demonstrated in the article ‘I feel so alone’:

Extract: 19

28 ‘It took me a long time to accept that I had mental health issues
29 but once I faced up to them and got the right help, my life took a
30 turn for the better.

These rhetorical devices work in conjunction with each other to justify and legitimize the need for medical intervention on the basis that psychiatric diagnoses are ‘real’ and ‘acceptance’ of the diagnosis is essential to restoring happiness or wellbeing. Again, these arguments are strengthened because in the ‘agony-aunt’ format of these letters, the author is positioned as speaking from personal experience, *corroborating* the dominant psychiatric discourse (Edwards & Potter, 1992; Gee, 2011).

A final example to demonstrate advocacy for medical intervention is shown below. This is taken from the article ‘She says she slept with my hubby’.

Extract: 20

21 ‘We split up and I tried to take my own life. I was hospitalised, and
22 thanks to the wonderful doctors, I made a good recovery. My
23 condition is now managed with regular counselling and medication.

In this excerpt the use of the phrase ‘thanks to’ and the adjective ‘wonderful’ arguably positions the doctors as ‘rescuers’ or ‘saviours’, without whom she might not be alive. This construction therefore invites the reader to respond admirably and respectfully to the doctors and legitimizes related medical interventions. The author then goes on to explain that their ‘condition is now managed with regular counselling and medication’, again echoing discourses of physical ill-health and the need for medical management (Walker, 2006).

3.1.2.4. Distress as a Biomedical Condition: Initial Summary and Reflections

In contrast to the ‘distress as normal’ interpretive repertoire, there is very little mention made to ‘causes’ of distress within this repertoire, as if having a diagnosis is an explanation in itself as opposed to simply providing a label. Indeed, the use of psychiatric labels is associated with particular connotations about causation, including ideas about genetic vulnerability and neuro-chemical imbalances (Walker, 2006). Fitting with a biomedical formulation are the constructions of distress as potentially being inherited by family members

(‘Should I tell my daughters the truth?’), and of being long-term and in the absence of any trigger (‘My life has been taken over’).

Another important consideration of this repertoire is, as in the case of the previous repertoire, its associated recommendations for action. This is also inherently important in the context of CDA. In this case, frequent references are made to the need for ‘acceptance’ that one has a psychiatric illness. This echoes work critiquing ‘insight’ in the field of ‘psychosis’ and ‘schizophrenia’. Dillon (2011) describes ‘insight’ in a biomedical context as representing an individual’s acceptance ‘that they are ill and that the cause of their distress is biomedical’. She goes on to describe the social actions associated with this biomedical construct, which ‘most usually means that ‘help’ is in the form of reliance on, and compliance with, long-term use of psychotropic medications and other interventions that professionals deem to be useful’. Those who fail to have ‘insight’, or in other words, those who have opposing views about the relevant factors contributing to their experience of distress, are seen as making ‘incorrect’ attributions – assuming that ‘psychologists and psychiatrists are privileged possessors of a correct theory of psychosis, which patients are foolish to dispute’ (Bentall, 2003). Whilst this body of work focuses primarily on psychosis, I would argue that the critique applies to a range of psychiatric labels. As represented in the magazines analysed, there is a pervasive notion that a person who does not ‘accept’ a psychiatric diagnosis is in some form of ‘denial’ and cannot accept the ‘truth’.

Another implication of the medicalization of distress, is that by placing the pathology within the individual we are obscuring important sources of distress such as poverty, unemployment, poor relationships, social isolation, violence and oppression, meaning that such harmful processes go unchallenged (Boyle, 2011; Rapley, Moncrieff & Dillon, 2011). These issues will be considered in more detail in the discussion section.

3.1.3. Distress as a Matter of Personal Responsibility

In this interpretive repertoire, distress is constructed as something manageable by the individual, given enough 'work' or personal effort. Two of the relevant articles analysed had an explicit 'self-help' focus, and a further three make explicit references to distress as something that the individual can control. This is in contrast to the previous section in which those diagnosed with psychiatric disorders were constructed as passive and out-of-control and advised to seek 'professional' help. In the four articles which were not explicitly 'self-help' focused, there was also a construction of distress as something that should be hidden from others. These constructions and the rhetorical devices used to construct them will be demonstrated below using extracts from the articles. The following excerpt is taken from the article 'Should I tell my daughters the truth?'

3.1.3.2. *Personal Responsibility to Control Distress*

Below is an entire 'self-help' style article selected from the data corpus. Whilst this article focuses on anxiety, it mirrors (both in format and content) a very similar article on Seasonal Affective Disorder (SAD).

Extract: 21

- | | |
|----|---|
| 1 | How to... reduce anxiety |
| 2 | More than one in five women say they suffer from anxiety most or |
| 3 | all of the time. Here are some fast ways to tackle it... |
| 4 | Check your diet |
| 5 | What we eat can have a huge impact on our emotional state. |
| 6 | Caffeine, for example, can intensify feelings of anxiety, trigger panic |
| 7 | attacks, and increase nervousness and irritability. And high-GI |
| 8 | foods such as white bread and sweets can cause blood-sugar |
| 9 | swings, which also make you feel on edge. |
| 10 | Get moving |

11 Maintaining a regular exercise routine reduces stress and helps you
12 to release tension. During exercise your brain releases serotonin,
13 which improves your mood.

14 Be positive

15 Write down three things at the end of each day that went well or
16 that you're grateful for. The more you are able to see the positives
17 in life, the less stressful most situations become.

18 Take relaxed, slow breaths

19 If you can relax your body, your brain often calms down too,
20 overriding your anxiety. Sit comfortably in your chair and count to
21 11 while breathing out. Then count to seven as you slowly breathe
22 back in.

23 Distract yourself

24 Reading a book, talking to a friend, watching something good on TV
25 or throwing yourself into a project at work can all distract you from
26 anxiety. When you're doing things, you have less time to worry.

There is ambiguity here about whether 'anxiety' is being used in a clinical or lay sense, but without this being made explicit, several rhetorical devices have been employed to construct the information as 'factual'. Firstly, the use of a statistic in the opening statement in lines 2-3 is an example of *empiricist warranting*, allowing for both the *reification* of anxiety as a commonly accepted and existing entity as well as presenting its reported prevalence as 'fact' (Edwards & Potter, 1992; Potter, 1996). Secondly, there is extensive use of both *physiological* and *biomedical* language in reference to anxiety. In lines 5-9, the author of the article writes about the physiological impact of eating particular foods the impact this can have on emotional state. This draws on scientific discourse around anxiety that assumes in referring to anxiety, we are referring to an existing emotional 'entity' that links to particular physiological and behavioural processes, as opposed to the idea that anxiety is a social construction (Hallam, 1985).

In lines 12-13, the reader is told 'During exercise your brain releases serotonin, which improves your mood'. Again this draws on *biomedical discourse*, and specifically on *neuro-chemical* language, through the use of 'serotonin'. This arguably draws on a number of rhetorical devices to present the information as 'fact' and minimise challenge. Firstly, *empiricist accounting* is used, as 'serotonin' and its impact on the brain is treated as an objective phenomena in its own right, which is simply being factually reported by the author. In addition, the global statement made about the brain releasing serotonin, in turn improving mood, is an example of *systematic vagueness*, as the claim is made with no explanation of the mechanisms by which this is possible. Edwards & Potter (1992) suggest that global formulations can be difficult to rebut or challenge 'while at the same time providing just the essentials to found a particular inference' (p. 162).

Importantly, in this particular article biomedical and physiological discourse are not just constructed as 'part' of the experience of anxiety, but are in fact positioned as being of primary significance. This is demonstrated in lines 19-20, where the reader is told 'If you can relax your body, your brain often calms down too, overriding your anxiety'. The adjective 'overriding' signifies something that is of more importance than other factors, and therefore constructs the 'physiological' as more powerful in the experience of distress than other factors, such as psycho-social factors.

As mentioned previously, it was not only the 'self-help' style articles that made reference to a woman's ability to 'control' or 'manage' her distress. This was also referenced in three of the 'agony-aunt' articles. For example, in the article 'Abuse destroyed my life', the author writes: 'With time and hard work, your past will no longer affect you as it's doing now'. Similarly, in another article about past abuse ('I'm too scared to get intimate'), the author writes: 'Letting go of your fears takes time and effort'. In another similar example, the author writes: 'Despite this, I'm picking myself back up again. It isn't easy by any means, but it is possible' (taken from 'I feel so alone'). These descriptions of the process of recovery are examples of *descriptions as attributions* (Edwards & Potter, 1992). The references made to 'effort' and 'hard work' position the responsibility for recovery within the individual, positioning it as within their control.

3.1.3.3. *Responsibility to Keep Quiet: Secrecy, Shame and Protecting Others*

Another feature of this interpretive repertoire is the construction of distress as something to 'hide'. In four of the articles, two of which were 'agony-aunt' style articles and two of which were 'real-life' personal stories, the author made references to hiding their distress. An example from 'Should I tell my daughters the truth?' is demonstrated below.

Extract: 22

8 It turned out that my grandma had also suffered mental health
9 problems and I grew up convinced that it would be my fate too.
10 Sure enough it was, although I've always been able to control my
11 depression and managed to hide it from my two daughters. They're
12 now in their teens and I wonder if I should be honest with them.

In this excerpt we are told that the author was 'able to control' her 'depression' and that she 'managed to hide it' from her daughters. Implicit in this description is that it is desirable for her to 'hide' her depression. As mentioned previously in relation to another extract from this article, the dominant discourse surrounding childhood in the UK is that of innocence and vulnerability (Meyer, 2007), and therefore within this framework the reader is invited to assume that the author 'hid' her depression to protect her children. This formulation also draws on *role discourse* (Edwards & Potter, 1992). Edwards and Potter (1992) postulate that actions can be justified or legitimised so long they are in keeping with a particular role or category assumed by the protagonist. In this case, therefore, the decision for a mother to hide 'depression' from her daughters is consistent with societal expectations about mothers (and women) as self-sacrificing and caring (Hays, 1996; Williams, 1999). However, a number of assumptions are implicit in this construction. Firstly it is assumed that 'depression' is something that children need protection from, and is thus something potentially harmful for others to be 'exposed' to. Secondly, there is assumption that mothers should 'silence' their own distress or needs for the sake of others.

Another extract which constructs distress as something to be hidden is shown below. This is taken from the article 'Monster in the cupboard'.

Extract: 23

53 My nightmares about him returned and I suffered anxiety and
54 flashbacks. I did my best to hide them. I didn't want to worry Mum
55 but I did agree to see a counsellor.

This article refers to distress in relation to past sexual violence. Here the author states that she 'did [her] best to hide' 'anxiety and flashbacks'. The use of the *superlative* 'best' constructs the author has having done everything within her capabilities to conceal her distress. The inclusion and placing of the following sentence 'I didn't want to worry Mum...' suggests that this was the justification for hiding distress, in order to protect her mother. Again this is consistent with societal discourses about women and self-sacrifice (Hays, 1996; Williams, 1999).

A final example is the following extract, taken from the article 'Mum at breaking point'.

Extract: 24

71 I'd never contemplated suicide but I knew what the thoughts I was
72 having meant.
73 I didn't dare tell Andrew about it, but I went to see my GP and I was
74 diagnosed with severe clinical depression.

In this extract the author describes having visions about taking her own life, and goes on to write 'I didn't dare tell Andrew [the author's husband] about it, but I went to see my GP...' The use of the verb 'dare' implies that it would take great courage or resolve to tell her husband about how she is feeling, although the reason for this is ambiguous. It could represent a shame or stigma around suffering, or it could represent a want to 'protect' her husband from how she is

feeling. The ambiguity in the text could suggest that there is an expectation that this would be implicitly understandable to the reader. One way this assumption could be understood is with reference to 'script theory', which suggests that we all have 'mental scripts' which tell us what to expect and how to respond in different social scenarios (Edwards, 1994). According to this theory, there would be an assumption that hiding distress represents a social 'norm'.

Whilst there were numerous examples in which psychiatric explanations of distress were constructed as something to be kept secret or hidden from others, there were exceptions to this pattern. Below is a respondent to the letter quoted in Extract 22 above.

Extract: 25

22 Hayley, 32: 'There should be no stigma surrounding mental illness
23 and they need to realise it's nothing to be ashamed of. Tell them.'

In this extract, the author can be seen to directly challenge the assumption that 'depression' should be kept secret. The use of definitive terminology such as 'should' and 'need' constructs the importance and necessity of this claim, and the use of the verb 'realise' constructs the argument against stigma as 'truth', which needs to be 'discovered'. However, it is important to consider the fact that, whilst this promotes an 'anti-stigma' view, it still constructs 'mental illness' as an existing pathology, thus *reifying* it (Potter, 1996).

3.1.3.4. Distress as a Matter of Personal Responsibility: Initial Discussions

In this repertoire distress is constructed as being manageable and controllable by the individual woman, given enough personal resolve. In many cases, distress is also constructed as something that should be hidden. In a critique of self-help literature, Kaminer (1992) argues that self-help is based on the notion that any individual has the capacity to 'overcome circumstances of nature and class – but only through adherence to systems that are devised or discovered by experts' (p. 46). In particular, self-help directed towards improving or changing mental states

frequently suggests that a negative state of mind is at the heart of all problems, as opposed to 'personal, political or social problems' (Kaminer, 1992, p. 47). On this basis, it could be argued that by positioning women as able and responsible for managing or controlling their distress, we are fostering a false sense of empowerment and obscuring the wider socio-political determinants of distress. Historically it has also been argued by some feminist writers that self-help has been employed to encourage women to adjust to and accept domestic care-giving (Hansen, McHoul & Rapley, 2003).

The notion that women should keep their distress hidden and secret is also arguably problematic. In the literature there is evidence to suggest that public attitudes towards psychiatric diagnoses negatively impacts those with such labels in a number of ways, including the direct treatment of those with a diagnosis, the institutional treatment they receive and internalized stigma (Angermeyer and Dietrich, 2006). Assumptions about keeping psychiatric labels (or experiences that may be interpreted as psychiatric disorders) hidden could therefore be considered understandable in this context.

Whilst stigma may be one explanation for secrecy, it also appeared to be the case in at least some articles that the primary reason for secrecy was to 'protect others'. This may be in part due to a want to protect loved ones from the effects of societal stigma, however it may also represent a dominant discourse in Eurocentric societies that constructs women as 'selfless' (Gilligan, 1982; Martin, 2003). According to Gilligan (1982), this relates to the construction of women as primarily relational, and therefore any behaviour or disclosure that could threaten relationships also create a threat to the woman's sense of self. The result is that women put the needs of others ahead of their own (Gilligan, 1982; Martin, 2003). The implications of the construction of women as 'selfless' will be considered further in the discussion section.

4. DISCUSSION

In this section I will first revisit the research questions and summarise the findings from the analysis section. In this process I also intend to expand on the analyses

by considering in more depth the implications of the findings on women and wider socio-political implications. This is consistent with CDA, in which the aim is to expose the roles discourse assumes in (re)producing social inequalities (Richardson, 2007). In addition to exploring the potentially harmful impact of such discourses, I also intend to reflect on who benefits and how such discourses are maintained. I will then go on to reflect on the implications for further research and for clinical practice. In this section I hope to apply the learning from the analysis and consider explicitly how Clinical Psychology can challenge harmful practices. I will then move on to a critical review section, and finish with concluding comments.

4.1. Research Aims Revisited

4.1.1. To critically analyse the way in which mental health and psychological distress are constructed in a widely read magazine targeted at women, with a particular focus on areas where the greatest gender divide exists

Throughout the analysis section I have aimed to clearly identify the key repertoires used to construct distress. In summary, these were the 'distress as a normative reaction' repertoire, the 'distress as a biomedical condition' repertoire, and the 'distress as a matter of personal responsibility' repertoire. Throughout the analysis I have endeavoured to identify and describe the different rhetorical means employed to create convincing constructions, and have begun to explore some of the potential implications of the different repertoires, both for individual women and wider socio-political implications. I will now explore the implications in more depth in the following section.

4.1.2. To discuss the potential impact this may have on women's understanding of their own mental health and psychological distress

4.1.2.1. Distress as a Normative Reaction: Key Implications

In this repertoire psycho-social experiences that are culturally accepted as legitimate causes of distress were posited as 'causes' for 'depression'. By drawing on commonly distressing experiences and placing them within a

psychiatric framework, this repertoire arguably serves to medicalize 'normal' life events in women. This echoes research by Metzl and Angel (2004), referenced in the introductory section of this thesis. In an analysis of pharmaceutical company advertisements for anti-depressant medication, Metzl and Angel (2004) found a gradual widening of categories of experiences relevant to women that were constructed as 'pathological/treatable' as opposed to 'normal/acceptable'. The medicalization of normal life experiences of women has many implications. Firstly, relying on media as a key source of information about mental health (Kalafetalis & Dowden 1997), women may too readily construct their own 'normal' experiences as symptomatic of pathology requiring professional intervention. This is consistent with findings from Kessler et al (1981) who noted that women are more likely to label their emotional experience as a recognised emotional 'problem'.

The ramifications of having a psychiatric label or being advised to seek 'professional' help in the form of Clinical Psychology, counselling or psychiatry can be devastating for some. Stigma in relation to psychiatric labels can have widespread and harmful effects including discriminatory treatment from others, impact on policy and 'self-stigma' (Angermeyer and Dietrich, 2006). With regards to self-stigma, it is possible that if women are to internalise the messages about pathology from the media, they may be more inclined to see themselves as unable and unfit, potentially impacting on multiple life domains.

In addition to direct implications for women, there are also a number of socio-political implications of medicalizing women's normal life events. Firstly, by placing the site of pathology in the woman, the harmful effects of the life events or social roles themselves remain unquestioned and unchallenged (Boyle, 2011; Ussher, 2010). As is consistent with CDA, it is important to reflect on the power structures that allow such harmful practices to continue. It could be argued that by pathologising women's normal experiences and advocating professional intervention, many powerful institutions are benefitting at the expense of women. Firstly, traditional Clinical Psychology operates on the assumption that we are able to alleviate an individual's distress by attending to the psychological processes through which the world is experienced (Smail, 2011). Consequently,

should the individual's distress be seen as a legitimate response to the 'noxious influences of a real, material world', as opposed to pathological psychological processes, Clinical Psychology risks being rendered useless (Smail, 2011).

Boyle (2011) argues that Clinical Psychology also colludes with the avoidance of examining socio-political context to avoid challenge from powerful groups such as psychiatry or government bodies. In exchange for this, she goes on to argue, Clinical Psychology is able to maintain particular academic and professional privileges. Psychiatry can arguably be seen to have similar vested interests in the pathologisation of distress, although this will be discussed in greater detail in the 'biomedical' section below.

From a feminist perspective, there is arguably much to be gained from the avoidance of exposing operations of power. By pathologising women's distress in relation to issues such as victimisation and the burden of their social roles, the powerful (for example, government agencies) are not obliged to address social and gender inequality (Boyle, 2011). In order to illustrate this point, I draw on the work of Vine and Kindersley (2009), who estimated that if women in the UK were to be paid for the caring work they undertake as a normal part of their social role, the cost would be an estimated 739 billion pounds a year. This can be seen to demonstrate the potential incentive in maintaining women in 'caring' roles.

4.1.2.2. Distress as a Biomedical Condition: Key Implications

Many implications of the previous repertoire also apply to biomedical constructions of distress. Namely, the individualisation of distress and pathologisation of women, and the advocated deference to 'professionals'. However, in this repertoire, women's distress is arguably taken even further out of social context, with no mention of psycho-social circumstances surrounding distress. Another key difference in this repertoire was the presence of numerous negative connotations associated with having a psychiatric label. As highlighted, these included being out of control, irrational and potentially dangerous. Unfortunately, these characteristics mirror unhelpful constructions of 'mental disorder' found to be commonly held in public discourse and media depictions

(Rose et al, 2007; Wahl, 1992), although some evidence suggests that more favourable attitudes are demonstrated towards common mental health 'disorders' (Angermeyer, 2002). As discussed above, such conceptualisations could have considerable implications for experienced stigma and self-stigma (Angermeyer and Dietrich, 2006).

Conceptualisations of distress as biomedical in nature also serve to legitimise medical and pharmacological 'treatment' for diagnosed individuals. As discussed in the introduction section of this thesis, this can have serious implications for individuals prescribed psychotropic drugs, which often come with a whole host of physically unpleasant and potentially harmful side-effects (Bentall, 2010; Davies, 2013). In addition to the physical side-effects, research has also indicated that 'patients' may also experience a number of unwanted emotional side-effects, including a sense of emotional detachment towards loved ones such as partners or children (Price, Cole & Goodwin, 2009). It may also be important to note that some anti-depressant medications are actually associated with a greater likelihood of the 'patient' ending their life (Healy & Whitaker, 2003).

As well as the harmful direct effects on women outlined above, there are also a number of socio-political implications for the medicalization of women's distress. Much of this echoes the discussion above, and in particular medicalized discourses serve to keep socio-political injustices hidden (Boyle, 2011). Consistent with a CDA approach, in the previous section I began to deconstruct the operations of power which serve to maintain the medicalization of misery, and in particular the medicalization of women's misery. In this section I would like to consider in more detail the role of psychiatry and the pharmaceutical industry.

With regards to psychopharmacological treatment, a further criticism in addition to the potentially harmful side-effects is that of effectiveness. In two large scale meta-analysis studies, Kirsch et al (2002; 2008) found that whilst there is a strong therapeutic response to anti-depressant medication, the response is only marginally less for placebo. In other words, whilst the drug effects of anti-depressants are not significant, the placebo effects are (Kirsch, 2011). However, in spite of questionable evidence for many psychopharmacological treatments

their use has continued to grow exponentially (Davies, 2013). Davies (2013) argues that this has been achieved through increasingly sophisticated marketing campaigns to support an industry worth billions of pounds. According to Moncrieff (2011), the central feature of this marketing campaign has involved selling a 'disease-based model' of drug treatment, suggesting that medication corrects a disease process in the brain, as opposed to a 'drug-based model' which is better supported by historical accounts and research evidence. Moncrieff (2011) argues that:

“Few people are aware that these concepts have their origins, not in robust scientific research, but rather in the interests of a psychiatric profession desperate to cement its professional position, and in the marketing tactics of the pharmaceutical industry” (p. 188).

As argued by Moncrieff (2011), the psychiatric profession also has investment in the medicalization of distress. Firstly, the very definition of psychiatric disorder is based on the assumption that the person is demonstrating or describing experiences which are not “an expectable and culturally sanctioned response” and which are “a manifestation of a behavioural, psychological or biological dysfunction in the individual” (Boyle, 2011, p. 36). In light of this, any suggestion that distress is meaningful and not pathological challenges the central tenets of psychiatry (Boyle, 2011). In addition, the psychiatric profession has a vested interest in the success of psychopharmacological treatment because the introduction of such drugs have been pivotal in establishing psychiatry as a 'science' (Moncrieff, 2011).

In light of this evidence, Kirsch (2011) argues that the central causes of depression (and other psychiatric 'disorders') need to be addressed. He argues that depression is associated with unemployment, poverty, poor education and unaffordable housing. In addition, Kirsch (2010) draws attention to evidence that people who benefit most from psychological and psychiatric interventions are white, well paid and well educated.

4.1.2.3. Distress as a Matter of Personal Responsibility: Key Implications

In this repertoire distress is constructed as 'manageable', with women being encouraged to overcome their distress with their own determination, or at least manage it well enough to hide it from others. This could arguably have a number of potential implications for women, including a felt sense of responsibility that they 'should' be managing, and 'should' be keeping distress from others so as not to burden them. As mentioned briefly in the analysis section, this appears to be consistent with a dominant discourse in Western societies that stipulates that women should be 'self-sacrificing', particularly in the context of certain roles such as motherhood (Hays, 1996; Williams, 1999).

Also implicit in self-help or similar advisory literature is the implication that anyone, given the right techniques, could overcome their cultural situation and take on more positive forms (Hansen, McHoul & Rapley, 2003; Kaminer, 1992). This could have a significant impact on the distress of individual women who may self-pathologise their dissatisfaction or unhappiness in the context of specified gender roles or gender inequality (Watson & Williams, 1992).

Self-help discourse, clearly, also has socio-political implications. Like the discussions in the previous repertoires, this construction serves to individualise distress and obscure factors such as gender inequality (Watson & Williams, 1992). As in the previous sections, it is important to consider the operations of power that are enabling these actions. The self-help industry is a lucrative one, and is dependent on positioning audiences (who are primarily women) as being in control of their misery and able to change it, whilst also being endlessly dependent on self-help and advice about feelings (Hansen, McHoul & Rapley, 2003). The self-help industry may therefore benefit both magazine companies which include such articles, as well as 'psy-professionals', by making profits and selling psychologised or medicalised notions of distress to women (Hansen, McHoul & Rapley, 2003). Smail (2011) argues that there is a dominant cultural discourse in UK society which suggests 'that our survival and success depend on our personal initiative and our ability to exercise responsibility (precisely the attributes so stifled, we are led to believe, by the 'outmoded' welfare state)'

(Smail, 2011, p. 237). Smail (2011) argues that this cultural belief legitimises psychotherapy as a profession, as individuals are primed to see themselves as culpable for their social circumstances and distress, and view psychotherapy as a route to 'self-improvement'. I would also argue that a similar argument applies to psychiatric management of distress.

Finally, it could also be argued that self-help and 'responsibility for well-being' discourses benefit other powerful individuals and agencies such as men and governmental bodies, because, in a similar way to the previous repertoires, if the site of pathology is in the woman, there is no responsibility to tackle political and social issues that cause distress (Boyle, 2011; Watson & Williams, 1992).

4.2. Implications

4.2.3. Implications for Future Research

One aspect of this research that was unique compared with previous research into women and distress in the media was the identification of a magazine that targeted women who, demographically, are most over-represented in anxiety and depression diagnoses. During the literature search I was not able to find any such examples, with similar studies targeting magazines that were widely read but not most commonly by women of lower socioeconomic status or women of the most 'high-risk' age range, or investigating popular newspapers that were not gender-specific (Bengs et al, 2008; Gattuso et al, 2005). I believed this provided a strong justification for researching the chosen magazine, but I am aware of the limitations of claiming generalizability of the findings on this basis and I have therefore endeavoured to make tentative claims and refer to supporting evidence in the literature. One possibility for future research could be to conduct a similar form of analysis on other forms of mass media targeted at women who are most over-represented and often most disempowered. I am aware that whilst I chose the best-selling women's weekly magazine in the UK that met my criteria, the sales statistics are still well below the viewer statistics for a great number of television programs, with television being the most consumed form of media in the UK (Diggs-Brown, 2011). In addition, research suggests that issues related to

mental health are frequently depicted in television programming (Cutcliffe & Hannigan, 2001). An interesting option for future research could therefore be to conduct an analysis of the construction of distress or psychiatric disorder in women in television programmes targeted at adult women who are mothers and of a lower socioeconomic status.

In addition, the current research focused solely on the language used in articles to construct distress, rather than also researching the visual component of articles. It could be argued that the analysis may have been enhanced by also taking the visual component of articles into consideration, such as accompanying images, charts, graphs and layout (Jäger & Maier, 2009), as these may have contributed to the rhetorical devices used. For example, the presentation of charts and graphs next to an informative column may have contributed to the construction of empiricist or factual discourse. Further research in this area, whether looking at data from magazines or television, may therefore benefit from analysing the visual in addition to the content of text.

A further consideration is one of power. A central value of this research was addressing gender inequality, and consistent with the principles of CDA, the project was conducted with the aim of actively challenging social inequalities with the hope of instigating meaningful change for women. As a white middle class woman and Trainee Clinical Psychologist and researcher, I am arguably in a position of considerable power in relation to many women accessing mental health services, who, as discussed previously often tend to be from disadvantaged groups (Belle, 1990; Hudson, 2005; Kessler et al, 1994; Lipman, Offord & Boyle, 1997). A valuable future direction for research could therefore involve the direct engagement of women from these groups in the research process. This could provide numerous benefits, but primarily I would like to reflect on the moral issue of power and participation. As highlighted by Beresford (2012), power and participation are inexplicably linked, with those in power (be they individuals, groups or institutions) being able to force less powerful individuals or groups to act in a specific way, even if this is against their will or not in their interests (Beresford, 2012). By involving women labelled with common psychiatric diagnoses in research, we are engaging in 'service-user activism'

which aims to address the inherent power imbalance between mental health professionals and service-users by making service-user voices more visible (Sweeney, 2013). This is of specific relevance to this research, as those women given psychiatric diagnoses are often the victims of damage caused by the medicalization of misery (Sweeney, 2013).

In addition, as touched on multiple times throughout this project, our own values and experiences as researchers will inevitably shape the research process. Given this, it is arguably both valuable and important to incorporate the voices of the disempowered in this process in a meaningful way, rather than simply reflecting the voices and agendas of those more powerful (Sweeney, 2013). By involving women who have used services or received psychiatric diagnoses, we are likely to gain new insights into methods of data selection, collection and analysis.

4.2.4. Implications for Clinical Practice

On the basis of my research findings I suggest three key implications for the discipline of Clinical Psychology. Firstly, I advocate for Clinical Psychology (and specifically critical approaches to Clinical Psychology) to engage more directly with the media. This is with the aim of challenging dominant cultural constructions of distress as rendering ‘sufferers’ passive and in need of professional intervention. Secondly, I suggest ways to limit collusion with a psychiatric model and discourses of personal responsibility for well-being in the context of one-to-one psychological therapy. Finally, I consider meaningful steps by which Clinical Psychology can engage with the *causes* of distress. By ‘causes’ I refer to the structural and socio-political inequalities discussed throughout this thesis and demonstrated to be key in understanding distress.

4.2.4.1. *Clinical Psychology and Engagement with the Media*

In the introductory section of this thesis, I discussed the power of the media in shaping public attitudes and knowledge about health and mental health (Ussher, 2010; Blum & Stracuzzi, 2004; Kalafetalis & Dowden, 1997), and in contributing

to psycho-social problems (Cusumano & Thompson, 2000; Davies, 2013; Grabe et al, 2008; Lynch et al, 2001; Watters, 2010). The findings of this study suggest that the main constructions of psychological and psychiatric distress apparent in the texts may have harmful implications. This is also consistent with previous research discussed in the introductory, analysis and discussion sections of this thesis (Blum and Stracuzzi, 2004; Gardner, 2003; Gattuso et al, 2005; Metzl & Angel, 2004). In addition, it is of note that Clinical Psychology had no mention in the data set, with references to talking therapies consisting of 'counselling' and 'cognitive-behavioural therapy' only. On this basis I would advocate that Clinical Psychology (and in particular, critical approaches to Clinical Psychology) should be doing more to engage with the mass media. However, this may well be met with challenges, and influencing public opinion raises issues with regards to both the effectiveness of such interventions, and ethical considerations about whose opinion should be changed and whose should be valued.

Whilst there are some powerful recent examples of Clinical Psychologists engaging with the mass media, these voices are arguably still marginalised and side-lined in favour of biomedical and psychiatric frameworks, and this is highlighted by the findings of both this study and those referenced in the previous paragraph. A recent exception to this was the statement issued by the Department of Clinical Psychology (DCP) of the British Psychological Society (BPS) in response to the publication of the most recent Diagnostic and Statistical Manual of Mental Disorders, the DSM-V (BPS, 2012). This statement openly critiqued the psychiatric framework for distress on the basis of the lack of evidence for biological causes, and the extensive catalogue of research linking psycho-social factors to distress (BPS, 2012). In the context of a critical psychology perspective, I would argue that this was a powerful example of a number of prominent Psychologists collaborating to engage with the media, challenge biomedical conceptualisations of distress and present alternative ideas. However, I would argue that this story was most widely reported in media targeted at those interested in critical approaches to mental health, and to middle-class left wing readership. This is illustrated by searching the BPS response in the search engine 'Google', which returns articles in The Guardian newspaper (The Guardian, 2013) and 'The Hearing Voices Network' (Hearing

Voices Network, 2013) on the first page of results. Whilst I would still advocate for Clinical Psychologist's engagement with such media outlets and organisations, I would also argue that by engaging with media outlets that do not target those most over-represented individuals in mental health services, we are potentially limited in our interventions as we may not reach the most disadvantaged groups. On this basis I would argue that Clinical Psychologists need to find innovative ways to engage with media outlets that target disadvantaged groups.

In addition to the challenge of engaging with media targeted at disadvantaged groups, Sayce (2000) also argues that changing public ideas about psychiatric explanations of distress is often unsuccessful due to the pervasiveness of the biomedical conceptual framework. However, she goes on to argue, based on the literature, that the public may be less cynical about alternative conceptions when messages are delivered by 'trustworthy' sources, and in particular, service-users themselves who challenge stereotypes (Sayce, 2000; Wolff et al, 1996a). In addition, evidence suggests that media-based interventions have more impact when backed by ongoing community-based education and action (Barker et al, 1993; Wolff et al, 1996a). This evidence provides a rationale for community-based social action as a key part of psychological therapy. This will be discussed further in section 3.2.4.3.

3.2.4.2. Feminism and Psychotherapy

In the context of traditional one-to-one talking therapy, Clinical Psychologists could actively draw on feminist thought with the hope of countering 'ideologies that ignore, deny and obscure the existence of sexual and social inequalities' (Watson & Williams, 1992). Whilst some feminist academics have argued that feminism and therapy are in themselves contradictory (with feminism focusing on material and social change, and therapy on psychological change) (Kitzinger & Perkins, 1993), I would argue that feminist principles can be used in a number of ways to counter harmful practices in psychological therapy and limit collusion with psychiatric frameworks (Boyle, 1997). However, I acknowledge that these are likely to be most effective when used alongside social and political interventions. Watson and Williams (1992) suggest that feminist practice represents an

approach to therapy rather than the prescription of particular techniques, and advocates the addressing of power imbalances between client and therapist and the explicit commitment to bring society and issues of sexual inequality into therapy.

Stoppard (2000) describes a number of ways that the goals outlined above can be achieved, including the therapist's adoption of the role of collaborator rather than 'expert' in an effort to counteract the lack of personal power women may experience in their personal lives. Stoppard (2000) also draws on adaptations made to specific approaches to take women's experience into account. To illustrate this point she describes cognitive therapy approaches which focus on changing assumptions about women's role of responsibility for pleasing the family and subjugating her own needs (Hurst & Genest, 1995; Stoppard, 2000). Whilst not a substitute for socio-political interventions, I would argue that by integrating such ideas into talking therapy, Clinical Psychologists are better able to acknowledge the 'real' of women's distress and make this more visible within the socio-political context as opposed to situating a pathology within the woman.

3.2.4.3. Clinical Psychology and Social Action: A Community Psychology Approach

Finally, in addition to engaging with the media and integrating feminist theory into psychological therapy, the findings of this thesis also indicate that as Clinical Psychologists, we need to be doing more to target the central causes of distress. As argued throughout this thesis, evidence suggests that distress stems from systemic factors such as social inequality, gender inequality, poverty and oppression (Boyle, 2011; Kirsch, 2011; Smail, 2011). Should this be the case, it provides a powerful rationale for why Psychologists, whose very business is in distress, should be actively working to target these issues. This is consistent with a Community Psychology approach to working with distress (Orford, 2008). Within such a framework, factors such as income distribution, social class, work conditions, and people's sense of community are seen as central to the psychological work (Orford, 2008). Within this approach, the Psychologist often takes on a number of different roles in addition to (or instead of) the traditional

'therapist' role, with aims varying from establishing personal, relational and/or collective wellbeing (Prilleltensky & Nelson, 2010). The work often has a preventative or early intervention focus, in that it targets the socio-political determinants of distress. In order to achieve these goals, Community Psychologists may collaborate with disadvantaged groups to promote community development and social action and to engage in research as well as working with individuals or groups to expose and challenge internalised stigma or oppression (Prilleltensky & Nelson, 2010).

Consistent with a Community Psychology approach, Holland (1990) argues that as Clinical Psychologists we are in a position to challenge gender bias in mental health provision and that one way in which to do this is to set up innovative services that actively target disadvantaged groups. This could arguably be used as a method to challenge Clinical Psychology's collusion with psychiatry by providing services and therapies according to diagnosis (Boyle, 1997), as well as actively implementing Community Psychology principles into psychological work. With respect to this research, there is arguably justification for the implementation of services targeted to adult women from lower socioeconomic status backgrounds, with a specific focus on lone mothers and those living in poverty. The White City Project set up by Holland (1990) is an excellent example of a Community Psychology project set up in collaboration with this very demographic. The project successfully demonstrated that women service-users can be enabled to set up local services which promote the idea of mental health as a community responsibility whilst retaining a group of mental health professionals as 'back-up' for support. This project involved more traditional one-to-one psychotherapy as well as 'consciousness raising' about social issues and their relevance to mental health. In concordance with this, women were supported to successfully lobby for action and social change in their local communities (Holland, 1990). I would argue that this model therefore provides a basis and rationale for the development of similar services elsewhere.

4.3. Critical Review

In this section I plan to critically appraise this research, taking into account methodological limitations and research quality.

4.3.1. Critical Review: Reflections on the Research

In this section I plan to present some initial reflections on the research before providing a more in-depth critique in the following sections. I will begin by reflecting on the use of a 'hybrid' approach, drawing on both DP and CDA. Using both approaches had the benefit of allowing me to examine the particular rhetorical strategies used in the text (using DP) whilst also creating space to recognise the power of media text and reflect on how particular conceptualisations of distress may be contributing to the medicalization of women's distress and positioning women in ways that may be to their disadvantage (using CDA). However, in practice, the analysis in this research drew more heavily on DP than CDA approaches, using CDA as a 'critical perspective' (van Dijk, 2009). This is opposed to 'pure' CDA approaches outlined by Fairclough (1995) and Richardson (2007), in which a more thorough analysis of the production and consumption of journalism is conducted, with the aim of highlighting relationships between journalism and social ideas and particular (often powerful) institutions. Whilst these analyses would have been interesting and relevant in the context of this research, this would have been difficult to include given both the size and time limitations associated with doctoral thesis research. The combination of these approaches may therefore have been somewhat ambitious in this research project.

A further reflection on the research relates to the use of a DP approach with artificial text. DP represents a useful approach when working with magazine and newspaper texts, and this is supported by an example included in Potter and Wetherell's (1987) book, 'Discourse and Psychology', which focuses on a newspaper article. However, DP as an approach is more commonly used to examine how language is used in naturally occurring speech to perform particular social functions (such as make an attribution of blame, or construct something as

fact) (Edwards & Potter, 1992; Edwards, 1999; Potter & Wetherell, 1987). When using DP in the context of media text, as is the case in this research, it is important to note that the particular rhetorical devices and interpretive repertoires used in the texts are likely to be a creation of journalists and media production processes, rather than reflect the language use of the identified 'authors' of the text (readers who have written to the magazine).

The final reflection included in this section relates to the analysis, and in particular the impact of a critical approach to biomedical constructions of distress. As highlighted throughout this research, as a critical psychologist and researcher I regard biomedical and psychiatric notions of misery and distress as problematic, believing they position people in ways that disadvantage them and obscure the role of harmful social and political processes (Boyle, 2011; Dillon, 2011; Smail, 2011). However, I am aware that the use of a critical 'anti-biomedical' lens in analysis could mean that some of the more helpful or constructive aspects of the interpretive repertoires 'Distress as a normative reaction' and 'Distress as a matter of personal responsibility' were obscured or unappreciated. This was particularly the case because in most instances, articles that constructed distress as a normative reaction simultaneously advocated for the individual to seek help from a medical professional. This meant that the more helpful connotations such as the normalisation of distress in particular contexts may not have been fully appreciated. Similarly, articles constructing distress as a matter of personal responsibility were frequently associated with secrecy and shame, which may have detracted from some of the more useful connotations of personal agency and power.

4.3.2. Methodological Limitations

4.3.2.1. *Magazine Data: Magazine as a Business*

The data used was 'naturally occurring data' as appropriate for DP and CDA approaches. However, it is important to consider the context within which this data arose. For the purpose of this research the magazine was conceptualised as a 'business' and the reader as a 'consumer'. Given this, it is important to consider

the notion that the magazine will likely be drawing on strategies to establish and maintain readership loyalty and increase sales and revenue (Richardson, 2007). In addition, an important point to note is that 'personal stories' printed in the magazine were advertised as paid, with readers being encouraged to share their own personal stories in exchange for a payment of up to two thousand pounds. Both the pressure on journalists to produce entertaining or interesting literature, and the financial incentive to readers to provide personal stories could have resulted in the creation of fictional stories.

Whilst this is worth noting, this research is based on the premise that language *represents* or reflects social 'realities' (or dominant discourses) whilst also *contributing to* social realities (Richardson, 2007). On this basis, it is not the 'reality' of the story that is of primary importance, but rather the constructions it uses and the potential impact this may have on the reader, or indeed on wider discourses in society.

4.3.2.2. Data Analysis: Discourse Analysis and Critical Discourse Analysis

According to Potter and Wetherell (1987), the focus of discursive psychology is exclusively on discourse itself. In other words, it solely aims to understand and describe how concepts are constructed and what the resultant social functions are of particular constructions. This is based on the social constructionist view that language is not simply the straightforward communication of what is in the speaker's 'mind', but rather a social action deployed to perform a particular function (Burr, 2003). For this reason, DP has been critiqued for not addressing questions of *subjectivity* (Willig, 2013). This means that whilst we can use DP to investigate public discourse, we cannot use it to explore internalised manifestations of discourse such as thought or sense of self (Willig, 2013). Additionally, DP focuses on how and why people deploy particular rhetorical devices to negotiate or manage particular interactions. By definition of this focus, DP does not allow for the exploration of *why* people adopt particular discursive objects. For example, why do speakers work so hard to disclaim particular attributions, and why do different speakers adopt or avoid using particular strategies (Willig, 2013). A final critique is that discursive approaches to data

analysis tend to limit the analysis to the texts that constitute the data, therefore ignoring the wider social and material context surrounding the text (Willig, 2013).

In order to counter some of the criticisms, I adopted a hybrid approach, drawing on both DP and CDA. This is because I was interested in the medicalization of distress in women as a particular social problem, and was therefore interested in how distress was constructed *as well as* the potential social impact of these constructions. The use of a discursive approach would have allowed me to explore the way in which distress had been constructed, and what rhetorical devices had been deployed to make arguments convincing and relevant. However, had a 'pure' DP approach been used, limited conclusions could have been drawn in relation to the potential *impact* of constructions of distress on readers. Similarly, I would have been limited in my ability to reflect on *why* particular constructions are used and who benefits from such constructions (such as Psychologists, Psychiatrists, or companies that own media outlets). I therefore drew on both DP and CDA throughout my analysis and discussions to allow me to focus my analysis on both the 'micro' and 'macro' levels of social construction (Burr, 2003).

Whilst the use of a hybrid approach had the advantage of allowing me to direct my analysis at both the 'micro' and 'macro' levels of social construction, I am aware that there may be inherent limitations in mixing different approaches, which could lead to a loss of coherence and integration in the research (Willig, 2013). However, I believe that such issues have been minimised through the adoption of an epistemological stance fitting to both approaches. In addition, neither DP nor CDA provide a prescriptive mechanical procedure for analysing data and producing findings (Fairclough, 2001; Potter & Wetherell, 1987), so by drawing on both approaches I was not straying from a particular identified, 'valid' way of conducting analysis. Indeed it has been argued by some researchers that by adhering too closely to a 'ready-made' methodology, one can risk compromising one's critical thinking and creativity (Chamberlain, 2012; Willig, 2013), and it can therefore be preferable to draw on different approaches to provide different insights (Willig, 2013).

4.3.3. Quality Assurance

Many contradictory positions are held about the appropriateness and usefulness of evaluating qualitative research (Spencer & Ritchie, 2012). It has been claimed that from a social constructionist perspective, the imposition of 'criteria' by which to judge quality are inappropriate, given that a consensus on quality would be arbitrary in an epistemological framework of multiple truths (Smith, 1984).

However, it is possible to evaluate the quality of qualitative research within a framework of 'guiding ideals' as opposed to specific positivist criteria (Seale, 1999). The framework I will use to assess the quality of this research is that outlined by Spencer and Ritchie (2012), which attends to issues of contribution, credibility and rigour.

4.3.3.1. *Contribution*

Contribution refers to the value and relevance of research evidence (Spencer & Ritchie, 2012). By definition, research adopting a CDA methodology is action-oriented, and therefore explicitly aims to explore and expose the roles discourse assumes in (re)producing social inequalities (Richardson, 2007). My hope is that this research builds on and brings together previous research critiquing the medicalization of women's distress (e.g. Ussher, 2010) and the potentially powerful and harmful role the media plays in promoting psychological and psychiatric constructions of distress (Hansen, McHoul & Rapley, 2003; Rose, 1998).

My hope is that, in addition to complementing previous research in this field, the current research also provides novel insights and unique contributions. Firstly, as discussed in the methodology section, no previous research has examined the construction of distress in media specifically targeted at women who are demographically most over-represented in common psychiatric diagnoses. The interpretive repertoires identified in the data may therefore be of particular relevance to this group of women and the way in which they experience and express distress.

A further aspect of the analysis worth noting in this section was the seeming contradiction with which particular interpretive repertoires were used. For example, even when distress was constructed as a normal and understandable reaction to a highly aversive experience, it was often simultaneously described with a psychiatric or symptomatic framework (see section 3.1.1.1.). This arguably reflects the contradictory views commonly held by lay people, which are often mediated by occupational background (Rogers & Pilgrim, 1997). This is of particular importance given that the conceptualisation of distress held by an individual will influence their response to distress. In addition, Rogers and Pilgrim (1997) report that discrepancies in conceptualisations of distress between mental health professionals and service users are associated with lower satisfaction in services.

Finally, another striking finding in this research was the absence of Clinical Psychology as a discipline despite such frequent references to misery and distress. Whilst frequent references were made to 'counselling', and two references to 'cognitive behavioural therapy', no explicit mention was made to Psychology or Psychologists or other models of talking therapy. This lack of representation may be highly significant given the promotion of biomedical explanations of distress and lack of 'critical' alternatives. Consequently, this lack of representation was one of the key drivers of my argument that Clinical Psychologists need to engage more with the media, and in particular media targeted at those who are most disadvantaged or most over-represented in mental health services (see section 4.2.4.1.).

In this research I also sought to make an explicit contribution by reflecting on the implications of this research for clinical practice and further research. My hope is that by deconstructing and exposing the interpretive repertoires and rhetorical devices used to justify psychological and psychiatric explanations of distress, I have been able to offer valuable reflections on the potentially harmful implications of these constructions, and the alternative constructions that remain hidden. Specifically, I have sought to expose the medicalization and 'psychologisation' of difficult life experiences and social inequalities, and reflect on the way in which women are routinely constructed as passive to their experiences and in need of

help from professionals. On this basis I hoped to propose useful insights into how harmful messages in the media can be challenged and alternative constructions of distress can be publicised and celebrated. In particular I have advocated for critical Clinical Psychologists to engage with the media, and I hope that I have provided a convincing argument for this by highlighting the lack of representation Clinical Psychology had in this widely read data sample and the power of media discourses. I also sought to provide valuable recommendations for clinical practice that will have a meaningful impact on women using mental health services.

4.3.3.1.1. Generalizability

As discussed previously, this study has not been conducted with the aim of claiming generalizability. However, as highlighted in the introductory section of this thesis, the potential power exerted by the media in shaping our conceptions of distress suggests that it may be valuable to consider the impact that the discursive objects in the text may have on the reader (Davies, 2013; Grabe, Ward & Hyde, 2008; Howitt, 1982; Kalafetalis & Dowden, 1997). This is particularly the case given the extent to which the findings from this study are supported by the literature (Blum and Stracuzzi, 2004; Gattuso, 2005; Metzl & Angel, 2004 & Ussher, 2010). In addition, as highlighted previously, according to Sacks (1992a) and McCarthy and Rapley (2001), it is likely that the examination of 'fragments of a culture' will elicit findings that can be found elsewhere within the same culture. In accordance with this view, it is likely that the constructions of distress identified in this research are also identifiable in other contexts.

4.3.3.2. Credibility

Credibility refers to the plausibility of the research (Spencer & Ritchie, 2012). To demonstrate the credibility of my research, I have sought to be as transparent as possible about the process of my data analysis, including an explicit description of the process used (in the methodology section), as well as an example extract of data analysis in Appendix 2 (section 5.2.). This was included to demonstrate categorisation and the identification of rhetorical devices and linguistic strategies.

During the analysis I have also included numerous extracts from the data to illustrate and support claims made, and have also made efforts to be explicit about why I have made particular claims and refer to relevant supporting evidence in the literature. In addition, in an attempt to demonstrate credibility I have also included examples in the data which do not fit directly with the key categories presented, for example, the example of a challenge to stigma and secrecy in the subsection 'Responsibility to keep quiet: secrecy, shame and protecting others', and the challenge to efficacy of psychopharmacological treatment in the subsection 'Hardship, trauma and the need for support'.

4.3.3.3. Rigour

Rigour refers to methodological validity, including the appropriateness of research questions, the dependability of evidence and the general safe conduct of research (Spencer & Ritchie, 2012). In order to demonstrate how I considered the rigour of my research, I will discuss how I managed issues of reflexivity and ethics and the defensibility of my research choices below.

4.3.3.3.1. Reflexivity

It is inherent to qualitative research that the researcher will influence and shape the research process (Willig, 2013). Throughout the process I have been aware that as a feminist and critical psychologist, I may be drawn to particular interpretations in the data that fit with my values. I became interested in this particular research project due to my own experiences of gender inequality, my passion for critical approaches to psychology and my personal and professional relationships with women. In particular, when working as an Assistant Psychologist on a women's inpatient ward, I became very curious about the way in which both staff and residents very readily pathologised the emotional experience of residents. Professionally, I have been particularly influenced by critical academics including Jacqui Dillon, David Smail and Mary Boyle, who fiercely defend the position that we should look at a person's experiences and the socio-political contexts that surround them to understand distress.

Whilst acknowledging that these values will have influenced my research, I have made efforts throughout the process to reflect on my assumptions. In conducting DA, the researcher is encouraged to notice and consider their reactions to the text (Wood & Kroger, 2000). Whilst this is in part to facilitate the researcher to identify the stance taken and the rhetorical devices deployed, this must also be considered within the context of the researchers own assumptions (Wood & Kroger, 2000). Throughout the analysis I have therefore made claims about the functions of discursive devices and wider implications tentatively. I also made efforts to be transparent about my interpretations and to search for and include examples in the data which did not necessarily fit with a critical approach.

4.3.3.3.2. Defensibility

Rigour also refers to the defensibility of approach in design (Spencer & Ritchie, 2012). In an effort to demonstrate this I have aimed to be transparent about my decisions with regards to data collection and methodology. As discussed in the introduction section of this thesis, I chose the particular magazine 'Take a Break' because it was the best-selling (and therefore probably most widely read) women's weekly magazine that specifically targets women who, demographically, are most over-represented in common psychiatric diagnoses. I also discussed in some detail in my methodology section my reasons for drawing on DP and CDA. Firstly, this type of analysis allowed me to examine medicalization of women as an identified social problem whilst also allowing me to attend to the 'micro' and 'macro' levels of social constructionism. In addition, by allowing me to expose potentially harmful discursive practices, this type of analysis lent to itself to active recommendations for change. As discussed in the 'credibility' section, I also evidenced my analytic steps with an example extract in Appendix 2 (section 5.2.) of this thesis.

4.3.4. Ethical Considerations

As discussed in the methodology section of this thesis, no participants were recruited for the purpose of this research project and the data used is publicly available, so issues of deception, consent and confidentiality do not apply. Willig

(2012) highlights three other ethical concerns for consideration when carrying out qualitative research. These include: keep in mind the research question and be modest about what the research can reveal; ensure the participant's voice is not lost and remain open to alternative interpretations. I will not describe each of these sections in detail here, as I have discussed these in some detail in other sections of this critical review. However, to summarise, I have kept the research question in mind throughout and discussions with colleagues and my director of studies has aided this process. I have attempted to be modest about my claims of generalizability and what the research can reveal. I have used extracts throughout the analysis in order to be transparent about the content of the data and demonstrate how I reached my particular interpretations. I have endeavoured to remain open to alternative interpretations and have actively sought out data that challenges my assumptions and values.

4.4. Final Summary and Concluding Comments

This research demonstrates that, at least in the magazine under study, normal life experiences for women are being medicalized and pathologised. A number of rhetorical devices are used to make this particular construction of distress persuasive, including the frequent use of corroboration (Edwards & Potter, 1992) in 'agony-aunt' style articles and empiricist and biomedical discourse positioning information as factual. This finding echoes much of the research evidence discussed in the introduction section of this thesis, which suggests that dominant discourses about distress in mainstream media negate socio-political factors and instead serve to individualise distress (Blum and Stracuzzi, 2004; Gardner, 2003; Gattuso et al; Hansen, McHould & Rapley 2003; Metzl and Angel, 2004; Ussher, 2010).

Examined within a historical context, this can be seen to follow a long tradition of the pathologisation of women's experiences of distress (Russell, 1995; Ussher, 2010), positioning them as more 'vulnerable' or 'maladaptive' in their coping (Hänninen & Aro, 1996; Nolen-Hoeksema, Larson, and Grayson, 1999) and ignoring the social context of gender inequality (Stoppard, 2000; Ussher, 2010). As discussed, the pathologisation of women can be seen to benefit the

powerful in multiple ways, including establishing a rationale for Clinical Psychology and Psychiatry (Boyle, 2011; Smail, 2011), earning profits for self-help industries and magazines, as well as pharmaceutical companies (Davies, 2013; Hansen, McHoul & Rapley, 2003) and maintaining women within 'self-sacrificing' roles that benefit men and governmental bodies.

Throughout this research I have sought to expose the discursive practices used to construct distress in ways that legitimises the above power abuses. On the basis of this evidence and supportive evidence in the literature, I have gone on to argue for a number of innovative interventions involving both research and clinical practice. I have argued that such interventions could be used to directly challenge harmful constructions of distress and meaningfully addressing the 'real' of distress experienced by women by directly acting upon the socio-political antecedents or determinants of distress (Smail, 2011; Stoppard, 2000; Ussher, 2010). My hope is that this research will provide some useful insights for Clinical Psychologists moving forward in the battle against sexual inequality.

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6. APPENDICES

6.1. Appendix 1: Literature Search Strategy

With regards to my literature search, I was initially interested in two broad areas: gender differences in psychiatric diagnosis, and constructions of distress and mental health in the mass media. I conducted my searches using the major online database 'EBSCO', and within this I specifically searched the databases 'Communication and Mass Media Complete', 'PsychARTICLES', 'PsychINFO' and 'PubMed'. I chose to search 'PsychARTICLES' and 'PsychINFO' as I was specifically interested in articles relevant to Clinical Psychology and mental health. Similarly, given the focus on medicalization of distress, it was also deemed appropriate to search the 'PubMed' database, which includes research in medicine and healthcare. Finally, I decided to include the database 'Communication and Mass Media Complete' because I also had a specific interest in the portrayal of distress and wellbeing in the media, and it was decided that expanding my search outside the health database might yield novel and relevant results.

In addition to the use of the above databases, I also used 'Google Scholar'. This was deemed appropriate because relevant data can sometimes be found here that is not accessible from the above databases, for example, reports from the World Health Organisation (WHO). In addition I did a library search for relevant books which may provide an overview of the topics. Finally I also looked up potentially relevant references from articles and books identified through the above searches.

I began my search by conducting a literature review on gender disparities in mental health. To accomplish this, I used the following search terms:

- Gender mental health
- Gender disparities mental health
- Gender differences mental health
- Gender mental illness
- Gender disparities mental illness

- Gender differences mental illness
- Gender psychiatric diagnosis
- Gender disparities psychiatric diagnosis
- Gender differences psychiatric diagnosis
- Sex differences mental health
- Sex differences mental illness
- Sex differences psychiatric diagnosis
- Women mental health
- Women mental illness
- Women psychiatric diagnosis

Much of the literature found on the basis of this search focused primarily on depression, so in an effort to gain a better insight into gender differences in other common psychiatric diagnoses (primarily anxiety), I also used search terms including various combinations of 'anxiety', 'sex differences', 'gender differences' and 'gender disparities'. Relevant articles were identified by reading abstracts and downloading full articles. I excluded articles that were not directly relevant to the research question. For example, in an article by Vogt (2014), the focus was on gender differences in mental health post-deployment in a war-zone. Due to the specificity of the context focused on in this study, it was not deemed to be of relevance to overall or epidemiological gender differences in common psychiatric diagnosis.

I then began a targeted search on constructions of distress in the mass media. To conduct this search I used the same databases and strategies, but used different combinations of the following search terms: 'Depression', 'Anxiety', 'Mental health', 'Mental illness', 'Gender', 'Women', 'Psychiatric diagnosis', 'Media', 'Constructions', 'Newspapers', 'Magazines', 'Stigma', 'Television' and 'Mass media'. Again, I also did a library search for relevant books and looked up potentially relevant references from articles and books identified through the searches.

6.2. Appendix 2: Example of a Worked Transcript

irrationality - behavior makes me happy but can't stop - no control

1 Katie Fraser's Take a Buddy

2 KATIE SOLVES YOUR PROBLEMS With a little help from her

3 friends

4 **extreme case formulation** - **powerless possibility**

5 My life has been taken over

6 C-T- Ever since I was a little girl I've had funny habits and behaviours,

7 biological and last year I was finally diagnosed with obsessive compulsive disorder (OCD). **there all along - 'realized' discovered**

8 I'm glad I have a diagnosis but I'm still struggling to manage my

9 condition - I scrub the floors and surfaces of my house constantly

10 and never invite anyone round in case they bring dirt or germs

11 inside. I've lost all my friends and I'm so lonely. **extreme case formulation**

12 no control psychosocial? TaB Buddy Emma, 23: 'I've had OCD for as long as I can - L.T. condition

13 remember. My main compulsion was hand washing - I'd scrub at

14 my skin until it was sore and bleeding. Because of this I stopped

15 going out and my friends drifted away. **unrationality** **unpleasant**

16 'All I wanted was to lead a happy "normal" life, but I believed it

17 would never be possible. In my darkest times, I even considered

18 ending it all. **rejection hopelessness** **professional** **CONTRAST**

19 'However, with the right help and treatment, I've learnt how to

20 control my compulsions, and I'm beginning to lead the kind of life I

21 always dreamt of. **romanticized** **personal resp but needed**

22 'It won't be long before you too get to this point. The hardest part is

23 admitting your problems and facing them. You've done this. Now go

24 and see your GP. **acceptance of biomedical**

25 'You may be given medication to relieve your compulsions - over

26 time, you'll find you need them less and less. Counselling is also a

27 good idea. **medication** **need implies** **vagueness?**

28 'Look on the internet to find a group for fellow sufferers meeting

29 near you. I attend a group three times a week. I can talk about

30 everything I'm going through and I've been given lots of tips and

31 advice. **discovery of 'objection'**

32 'If you'd like to talk to me in person, ask Katie for my email address.

need **pgs - possibly** **acceptance + need to learn - empowered, positive**

relying on diagnosis or answer? explanation

psychiatric disease

request - minimize

combobated?

speaking with authority of experience

medical psychiatric biomedical

casualty

6.3. Appendix 3: Ethical Approval

ETHICAL PRACTICE CHECKLIST (Professional Doctorates)

SUPERVISOR: [REDACTED]

ASSESSOR: Anna Butcher

STUDENT: [REDACTED]

DATE (sent to assessor): 09/06/2014

Proposed research topic: The Overrepresentation of Women in 'Common' Psychiatric Diagnoses: Do Women's Magazines Play a Role in Marketing Psychiatric Explanations?

Course: Professional Doctorate in Clinical Psychology

1. Will free and informed consent of participants be obtained? N/A
2. If there is any deception is it justified? N/A
3. Will information obtained remain confidential? N/A
4. Will participants be made aware of their right to withdraw at any time? N/A
5. Will participants be adequately debriefed? N/A
6. If this study involves observation does it respect participants' privacy? NA
7. If the proposal involves participants whose free and informed consent may be in question (e.g. for reasons of age, mental or emotional incapacity), are they treated ethically? N/A
8. Is procedure that might cause distress to participants ethical? N/A
9. If there are inducements to take part in the project is this ethical? N/A
10. If there are any other ethical issues involved, are they a problem? N/A

APPROVED

YES	YES, PENDING MINOR CONDITIONS	NO
-----	-------------------------------	----

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: AB

Date: 10th June 2014

RESEARCHER RISK ASSESSMENT CHECKLIST (BSc/MSc/MA)

SUPERVISOR: [REDACTED]

ASSESSOR: Anna Butcher

STUDENT: [REDACTED]

DATE (sent to assessor): 09/06/2014

Proposed research topic: The Overrepresentation of Women in 'Common' Psychiatric Diagnoses: Do Women's Magazines Play a Role in Marketing Psychiatric Explanations?

Course: Professional Doctorate in Clinical Psychology

Would the proposed project expose the researcher to any of the following kinds of hazard?

- | | | |
|----|--|----|
| 1 | Emotional | NO |
| 2. | Physical | NO |
| 3. | Other
(e.g. health & safety issues) | NO |

If you've answered YES to any of the above please estimate the chance of the researcher being harmed as: HIGH / MED / LOW

APPROVED

YES	YES, PENDING MINOR CONDITIONS	NO
-----	-------------------------------	----

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: AB

Date: 10th June 2014

For the attention of the assessor: Please return the completed checklists by e-mail to ethics.applications@uel.ac.uk within 1 week.

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.



School of Psychology Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

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